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## CLINICAL LECTURE.

AMPUTATION BELOW THE KNEE—ARTIFICIAL ANUS—SARCOMA OF SHOULDER—RADICAL CURE OF HERNIA—CARCINOMA OF BREAST; REMOVAL—TUBERCULAR ARTHRITIS OF KNEE-JOINT; EXCISION OF KNEE-JOINT.

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### AMPUTATION BELOW THE KNEE.

*Gentlemen:*—Our first case this morning is an old one, which I operated upon in last Wednesday's clinic. I bring the patient before you to-day merely to show you the result of the operation, which—as you will remember—was an amputation of the leg, below the knee.

You see the results, so far, are perfect. Not a drop of pus has formed; and from the one remaining drainage tube there has been only a slight serous discharge. The largest part of the wound has healed by first intention. The flaps are also of good color, and apparently well nourished. The patient has only had an immaterial rise of temperature, has a good appetite and looks well. Had this been an ordinary amputation, these results would naturally have been expected, since the operation was conducted antiseptically. But the young man you see before you was brought here for operation in an apparently moribund condition, suffering from an aggravated case of gangrene following a crush of the leg, and to get my flaps I was forced to go dangerously near the diseased parts. The results are a surprise to me, for at the time of the operation the patient's chances for recovery were very slim. Even now we cannot feel justified in giving an absolutely favorable prognosis, although the probabilities are that a complete ultimate recovery will be the result.

This case is an example of the value of anti-septic surgery even in cases already gravely infected. Not only can we almost invariably prevent septicæmia or gangrene—but even when those conditions pre-exist, can frequently check their course. Such results as these are always most gratifying.

### ARTIFICIAL ANUS.

I shall as quickly as possible show you the results of the other operations I performed at the last clinic. I am glad to be able to report that all are doing excellently well; not a drop of pus in a single case.

This man was operated upon for carcinoma of the colon. His condition was truly a pitiable one. Besides the colon being carcinomatous in almost its entire length, he also had a recto-vesical fistula, and was passing fecal matter through his bladder. His sufferings were intense. I performed colotomy, opening an artificial anus in the left groin. The patient is now doing well; he has had several large and comfortable stools through the artificial anus, and the fecal matter in the urine is growing less. What is now in the urine is probably from feces that were in the lower part of the colon before the operation, and will soon disappear.

Of the course this can at best be only considered a palliative operation, but it prolongs life and alleviates suffering.

### SARCOMA OF SHOULDER.

This is also an old case, and has been doing remarkably since the operation, which was performed a week ago. The case was one of sarcoma of the shoulder. The growth was an enormous one, involving the shoulder joint and humerus, necessitating a very large wound and making the operation a formidable one. To-day you see that the wound has entirely healed by first intention with the exception of one point in the track of a drainage tube. There has been no pus, and no material elevation of temperature. The patient's condition is excellent, and she is now practically out of danger.

## RADICAL CURE OF HERNIA.

The last of the cases operated upon last week was that of this man, over 70 years old, who had a very large irreducible hernia. It was undoubtedly the worst case I ever operated upon. The results of the operation can be fairly called perfect. Healing has been entirely by first intention, and there is no evidence of any return of the hernia. This slight swelling over the wound is due to œdema, not to a return of the hernia. Whether or not the operation will prove itself truly a "radical cure" remains yet to be seen, but the prognosis is undoubtedly good.

## CARCINOMA OF BREAST.

The first case for operation to-day is one of carcinoma of the breast. The patient is a woman fifty-four years old. Before proceeding to the operation let me tell you that the two kinds of growths most frequently met with in the breast, are sarcoma and carcinoma. The following points are valuable for differential diagnosis. Sarcomata are soft; they occur before or during the middle of life; the skin is free and not involved, except that there is usually a venous enlargement. Carcinoma, on the contrary, usually occur late in life; the skin is adherent; the growth is hard, and frequently nodular, and the nipple retracted.

The latter symptoms are all present in the case before us.

The first step of the operation is to make two superficial incisions across the growth in the form of a crescent. We then proceed to dissect out the growth. One of the superficial incisions should extend well down into the axilla to facilitate the cleaning out of this part. Never run the risk of including diseased tissues in your flaps, or in your fear of removing too much and leave infected tissues behind. Also never fail to remove such portions of the pectoral muscles as are attached to the tumor.

One part of this operation which, for a subsequently successful result, requires the utmost care, is the thorough cleaning out of the axilla. In these cases the neighboring lymphatics are always infected and should therefore be carefully removed. This part of the operation is also by far the most difficult. Over the pectoral region we are comparatively safe, no large blood vessels being near, but here, in the axilla, we are working among a net work of large veins and arteries. You see I not only remove the lymphatic glands, but also any loose pieces of fat or tissue; in fact clean the whole axilla out,

leaving nothing that might act as a seat for further infection.

Having now removed the growth, I bring the edges of skin together, and find that they approximate nicely. The wound is now closed with a row of sutures and dressed antiseptically, all bleeding points, which during the course of the operation have been caught by hæmostats, having been tied.

Before going to the next case, let me reiterate the necessity of removing all diseased tissue. It matters but little whether the wound is entirely covered by skin or not, but it is of the greatest importance that every particle of diseased tissue be removed, whether it be muscle, or gland, or skin. Unless this is accomplished, your operation will be worse than useless.

## TUBERCULAR ARTHRITIS; EXCISION OF THE KNEE-JOINT.

The history of the young woman before us is one of tuberculosis. Several members of her immediate family have died of consumption. The patient herself has been suffering from an enlargement of the knee for some time, and has faithfully tried various methods of treatment, including the rest cure. But to no avail, and she is now practically a cripple, being unable to use the limb in any way. From the family history and the local evidences, the case is evidently one of tubercular arthritis of the knee-joint and we will excise the joint.

You see I elevate the limb as high as possible to render it bloodless. This is often a more satisfactory procedure than applying an Esmarch bandage in such cases, as forcible pressure could very possibly rupture a distended capsule and drive tuberculous or purulent material into the tissues above the joint. Indeed, I have not unfrequently seen this to be the case, and serious suppuration follow in consequence. Then again, there is nothing to be gained by the application of the bandage, since the limb can be rendered equally bloodless. This being accomplished we now place an Esmarch tube above the knee to control all possible hæmorrhage.

The operation of excision of the knee-joint consists in making a straight incision across the joint, turning up the flaps; removing of the patella; sawing off of the condyles; a thorough cleaning out of the joint; drainage; an antiseptic dressing, and the application of a suitable splint.

After having made my superficial incision, and having removed the patella by severing its tendinous attachments, I find that

the under surface of this bone is necrosed. The head of the tibia is also badly diseased, as are also the condyles of the femur. I find a large mass of synovial tissue and other evidence of tuberculosis. This confirms our initial diagnosis of tubercular arthritis of the joint. I am careful to remove all these infiltrated tissues, since if left behind they would undoubtedly be new foci for an extension of the disease. I divide the lateral ligaments freely. I saw off a good deal of bone from both the head of the tibia and condyles of the femur, three quarters of an inch at least, on account of the necrosed and softened areas which extend beyond the surfaces of the bones. You see these fresh bone surfaces look healthy, and straightening the leg, I find that they fit snugly together, leaving the limb in a more normal position. This operation is now practically completed, care being taken that all loose tissue is removed. Personally I prefer to ligate all bleeding points, but many operators depend merely upon pressure and elevation for the arrest of hæmorrhage. The wound may now be closed, an antiseptic dressing applied, and the limbs placed in a well-padded Gooch's splint. The prognosis is good.

#### THE TREATMENT OF SYPHILIS.

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*Gentlemen:*—I will now present to you a man with the characteristic rash of a secondary syphilis. He is 24 years of age, who had a gonorrhœa, a few months ago for the first time, and a chancre seven weeks ago, with no history of the period of incubation.

I wish now to speak to you a few words on the proper way of treating syphilis. In the first place, do not treat the initial lesion by the use of strong caustics, cold water dressings, lead water, lime water, or the black or yellow wash. Always bear in mind that absolute cleanliness is the true foundation of all treatment. When there is any tendency to ulceration in the lesion, by burning the parts vigorously you only cause the inflammatory areola to break down in ulceration at a later period. The very best remedy to use for the initial lesion of syphilis of all that I know of is iodoform, and you get that in the pleasantest form

possible, under the name of Merck's iodoform. I wish to give you a point in this connection. We hear a great many people say that they cannot use iodoform on account of its odor, and it will be smelled by everybody. If you use iodoform carefully, and in small quantities, people will not be able to detect its presence. In other words, when you are dressing a chancre with iodoform, be careful that the iodoform does not get on the clothes of the patient, put on only sufficient to cover the sore, place a piece of cotton over that, and then draw the prepuce forward over the cotton. Then you can use iodoform or aristol, if you choose, instead of iodoform, but neither of these is as good for this purpose as iodoform. Aristol is a good remedy to employ where there is not a very active stage of ulceration present.

If there is a good deal of hardness present and the chancre is "lumpy" it is well to wash the parts first with soap and water, and then with a five per cent. carbolic acid solution, dressing it with blue ointment.

When a man comes to you like this one, it is your duty to make the unpleasant fact known to him that he has syphilis as gently as you can, but with all the seriousness that the case demands. Impress upon him the necessity of his continuing under treatment for the next two years at least, and, in the majority of cases, you will find, if they start in with a good constitution, they will come out cured of their trouble at the end of that time. The idea that syphilis is an incurable disease is based upon the information that there is a diathesis behind all the stages of this affection which we are powerless to treat, and that our therapeutic measures are utterly useless in this respect. There are some cases, however, that will act badly, but by care and attention, and with a knowledge of the proper remedial agents, you will be able to tide them over their difficulties in time. Then again, there are other cases that, even with the best of care and attention, this diathesis seems to get the better of them and obtain complete mastery for a long period of time. You must bear in mind that syphilis is a constitutional disease, the tendency of which is to lower the vital powers and develop certain lesions which may be the means of producing invalidism in your patient and perhaps death. It behooves people, therefore, who have syphilis, to put their house in order, so to speak, and keep their health up to the highest possible standard of development. This is in reality the keynote of successful treatment



in these cases of syphilis. A man came to my office the other day with a minute chancre of the upper lip, so slight as to be hardly recognized from a herpes. He had enlarged submaxillary glands also. He told me he had a project by which he could make a large amount of money, and he wanted to know if I thought he would be able to undergo a certain amount of mental strain which this scheme would devolve upon him. I told him practically no, and informed him that he was in a condition in which he was not warranted to draw upon either his physical or mental resources. That it was his duty to husband his vital forces and not draw upon them for present use. If a man worries and bothers himself about the business and cares incident to a financial life, while under the influence of the syphilitic infection, you can well understand that this strain upon his nervous system is going to do him harm, and your treatment of his case by the therapeutic measures at your command will not result in much practical benefit to the patient. In treating a patient with syphilis put him into as good a mental and physical condition as possible, for, bear in mind this one fact, that the effect of the mind on the malignity of syphilis is very great indeed.

If your patient be a drinking man he must stop this habit, but it does not follow because a man has syphilis, you should teach him prohibition doctrines. There are a good many of those men who are accustomed to the use of a glass of beer or ale, and there is no valid reason that they should not be permitted to take a glass or two a day, if they want to. They should be advised to go to bed as early as practicable, avoid catching cold and over-fatigue. In other words they must not put their mental or physical qualities to the test in the way of over-fatigue or over-exertion. Time and time again can I look back and see children grow up to puberty vigorous and healthy, both mentally and physically, whose parents I have treated for syphilis years ago. It is always well to impress these patients with this hope of an ultimate cure, because there are some whom you will find it difficult to keep under treatment and observation for a proper period of time.

If a patient with syphilis has some little functional trouble, as for instance, a bronchitis, look out for that trouble. Having this chronic infectious disease he is very liable to have some pulmonary trouble added thereto. It is always well for a patient with syphilis to guard himself against exacerba-

tions or development of that infection and in that way he will avoid the complications of the disease.

Some of you, no doubt, have read in the books that syphilis is largely a mathematical problem, and by regarding it as an abstract factor, they compute in figures the amount of mercury required for this abstract problem. This is a very routine way of treating this disease. Every case of syphilis is a law unto itself, and a dose which affects one man favorably, will affect another man unfavorably. A dose which will remove the poison in one patient will prove utterly powerless in another.

In the case of this man before us who presents with the first general manifestations of the disease you would not give him iodide of potassium. This drug is contra-indicated in the earlier stages of syphilis, except there be some severe trouble of the brain or periosteum. The proper way to treat this man would be to give him a pill of the protoiodide of mercury, for of all preparations of this drug for internal use the proto-iodide of mercury is the best.

There is no necessity for the use of any tonic in this case, though in a good many patients you will find it very essential. As a general formula you will find the following a very good one:—

R

Hyd. protoiodidi.....viii gr.  
Ferri et quin cit..... 5 jss  
Ext. Hyoscami..... vi gr.

M. ft. Pill xxxii. S. Three a day.

If under the use of this medicine the glands are going down the remedy is doing your patient good, and you ought to keep him on this treatment for a month at least, but, if on the contrary, the remedy was not acting properly and your patient was not showing any signs of improvement under its use, then you can increase the dose of mercury to be given each time. You will rarely have to give more than three grains of the protoiodide of mercury a day and four grains will be the maximum amount you should give in the twenty-four hours, for if you do not produce the desired effect with that dose, you are not going to produce it all. At the onset of the disease it is well to give large doses of this drug and always inquire of your patient how it is acting. Ask him how he is feeling, whether he is losing or gaining in weight, whether his thoughts are clear and capable of the same amount of mental strain as before the onset of the disease, and these points in the treatment of syphilis will be a guide for you in your medication of the patient.



Some people will tell you that the guide to the availability of mercury depends entirely on the mouth. Such a view as that is erroneous. If, after the use of mercury for two or three weeks, you observe the condition of the gums and find any trouble there, touch them with the solution of iodine and keep up the use of the mercury. The mouth often becomes irritated by reason of defect in it, and the mercury will be well borne and produce its physiological effect if you keep the mouth in a good state. It is always a good plan to make peace with the mouth under these circumstances. The tests of the efficiency of your mercurial treatment is then the rapidity with which the lesions of syphilis vanish. It is well to give your patient for the first two or three months the protoiodide of mercury and then stop for a while, giving him the iodide of potassium and the tincture of gentian for a week or two. If in the early stages of the disease you cover four, five or six months with your treatment, you are going to cure your patients more efficiently than by giving them an interval of rest in the early stages of the disease. Every day during the first year of syphilis is a matter of vital importance, for during this time the disease is more amenable to treatment than at any other period of its history. Keep these patients as persistently and as constantly as you can during the first six months under the use of the mercury. Old Ricord used to say that he could cure syphilis in six months. In many cases he no doubt would, because he would keep the patient continuously under observation and treatment.

There is a limit to the use of the protoiodide of mercury in syphilis. It is well to give it for the first month or two and then to use inunctions of the mercurial ointment. And here let me in this connection say a word about the use of the pill, hydrargyri. The blue pill is about as uncertain and capricious a remedy as you can get. It simply amounts to this, that when it is pushed on the patient, it will produce salivation as rapidly as possible, but when it is acting blandly, it is doing nothing at all. It is one of those drugs that you do not know in what way it is going to act. I have studied this subject with great care for many years, and I may say this, that the therapeutic effect of the protoiodide of mercury after two months of the disease is absolutely nil. It seems to develop in the system of the patient a tolerance for the drug, and possesses for no longer period the power of dissolving, destroying, or burning

up these small round cells which constitute the evidence of syphilis. Therefore, after having given these pills for the time I have stated, then begin with your inunctions of the mercurial ointment. Take thirty, forty, forty-five grains of mercurial ointment and have it thoroughly rubbed into the arm, having previously washed it with soap and water and then with a solution of carbolic acid. As the disease commences around the blood vessels in its permeation through the system and the lymphatics are its chief channels of distribution it is, therefore, always well to act on the glands whenever you can do so. Therefore, have the axilla well washed out and the ointment well rubbed in there. If you see any irritation over the parts cover it with Laselle paste which is composed of two parts of starch, two parts of oxide of zinc, with four of vaseline, to which may be added four or five per cent. of carbolic acid. In that way you will keep down the dermatitis. In giving the ointment, it is a good thing to have the whole neck up to the scalp rubbed in with these inunctions, for in that way you bring the mercury in contact with the whole surface of the body. You are in this way accomplishing two things, you are destroying those small cells that develop in the skin, and you are, at the same time, permeating the skin with the mercury which is producing its effect on the glands. It has been shown that by excising portions of the skin near the genitals in parts remote from the seat of the initial lesion you find small cells in the skin under the microscope. Therefore, you should bring your mercurial ointment into direct contact with the whole skin. You can cover the whole body in seven or eight rubbings, but these rubbings must be done faithfully and intelligently. Having gone over the whole body it is well to give the patient rest for three or four nights, and while he is taking the inunctions it may be advisable to ask him if his mouth is sore, if he has a diarrhoea, or pain in the stomach, does he sleep well at night, and is he nervous or depressed. If he replies no to these inquiries, then that is all right, and you are treating his syphilis efficiently. Continue with your inunctions till you have given your patient forty or fifty rubbings, and as a general thing, thirty-five or forty grains of mercurial ointment, will be sufficient. In this city, however, a patient cannot stand that amount of mercurial treatment, but if he were out in the open air with nothing to do and free from care and busi-

ness, he can stand a good deal more of this kind of treatment than if otherwise situated. There is no law regulating the amount of mercurial inunction you use in a given case to guide you but your own judgment. If your patient be a poor, weak, individual, perhaps twenty-five grains of the mercurial might be enough, and if he be a robust, vigorous man, he may require as many as sixty grains. It is always well to wait, before giving these inunctions, till the secondary symptoms begin, so that you may know where you are, except where the lesion may make its appearance on the mouth or face of the patient and proves to be a menace to the health of those that surround him. While you are giving these inunctions, you can make use of the stomach for the purposes of tonic treatment. In giving these patients treatment, impress upon them the absolute necessity of rest and recreation. During the summer have them go away to the country as long as possible, and as an aid to the inunction treatment, let them take very hot baths in order to produce free diaphoresis, or have them go to the Turkish baths. Stimulating the circulation and producing diaphoresis in this way seems to scatter the mercurial ointment throughout the system.

In some cases you will find that regional treatment is necessary, and it may be necessary to have certain parts covered with the ointment all the time. Push this treatment on for the first year with the mercurial.

But suppose that your patient cannot use mercurial inunctions, what then is to be done? In such a case as that you have a sovereign remedy in the injections of mercury. There is no preparation that I have found, and I have been using it now for over 23 years as an injection, that has given me better results in this respect than the bichloride of mercury. Get an ordinary hypodermic syringe, keep it in the cleanest possible condition, cleanse the surface of the body you are going to inject, and then inject under the skin one-sixth, one-eighth or one-twelfth of a grain of bichloride of mercury in ten minims of water, and in that way where the stomach fails, where the inunctions are inadmissible, you will find that you have a remedy that will not disturb the stomach, and will affect the syphilitic infection favorably, while at the same time preserving the stomach for the use of medicines that will build the patient up. I never experienced so much difficulty in the treatment of these cases as I have had this

winter, and have found great help from these injections.

Now to sum up the treatment of these cases, I would say push on for the first year your mercurials, giving your patient a couple of weeks rest after the first six months, and then toward the end of the first year you can use your combination of mercury and iodide of potassium, or the so-called mixed treatment. The following formula you will find very satisfactory:

**R**

Hyd. Iodidi,.....iij to ix grains.  
Potass. Iod.,.....iv 3 to vi 3.  
Aque. ad,.....3 iv.

M. and S. A tablespoonfull three or four times a day as the case requires.

Push this treatment on the second year, and you will generally find that your patient will be cured. In the vast majority of cases you will have the best result follow such a treatment as I have here given you in cases of syphilitic infection.

## COMMUNICATION.

### THE SPECIFIC AND THE NON-SPECIFIC TREATMENT OF PULMONARY CONSUMPTION.<sup>1</sup>

BY THOMAS J. MAYS, M. D.

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It goes without saying that the successful treatment of pulmonary consumption depends entirely on a correct and rational view of its origin. On this ground, there can be no division of opinion. Unfortunately, however, one part of the profession holds that the tubercle bacillus is the sole cause of the disease; while the other part believes that the disease depends on numerous other causes, and that the bacillus is merely one of its products or concomitants.

Now, it must be confessed that diametrically opposite opinions on a question of such tremendous practical and public importance, is no great credit to a profession which is justly proud of her logical conquests, and which rightfully rejoices in her scientific achievements, and in her work of philanthropy. Especially is this a misfortune when we consider that the whole difficulty rests on an erroneous interpretation of the fundamental terms which are involved in

<sup>1</sup> Read before the meeting of the Pennsylvania State Medical Society at Reading, June 3rd, 1891.

the question; and in endeavoring to prove this, I desire it to be perfectly understood at the outset, that I yield to no one in my admiration of, and I might even say in my veneration for those pains-taking explorers who so patiently and assiduously devote their life and energies to the investigation of this fearful malady. But I do not regard this as a question of personal reverence. It is one which must determine the true relation of the consumptive to his family, to his friends and to society; whether or not he is to be looked upon as a center of infection, a source of danger, and liable to spread the disease among those who are well.

Where then lies the fundamental misapprehension? It is (1) in affirming that, because a disease is capable of being communicated from one animal to another through inoculation, that, therefore, it must be contagious or infectious among the human species; (2) in holding that the disease (tuberculosis) which is produced artificially in animals through inoculation, is the same as that (consumption) which is naturally produced in man; and (3) in assuming, that, because an immunity can be created in animals by inoculations with a modified form of the tubercle virus, the same can be done in man. Furthermore, there is no warrant for believing that a disease can be cured by antogonistic inoculation unless it is clearly infectious or propagated from man to man through contagion.

The whole inception and progress of the infectious theory of consumption rests on animal experimentation, and recent history still reverberates with the assurances that the key to the cure of this disease was lying waiting in the lap of the experimentalists, whose dicta were to be blindly accepted whether they accorded with clinical experience or not. I am a firm and positive believer in the immense good which comes from well conducted laboratory research, and I think I have given sufficient practical evidence of my high appreciation of such work; but I also recognize the fact that the great bane of modern medicine is the tendency to subscribe to the premature conclusions of experimentalists which are wholly unsupported by bedside experience.

Professor Semmola of Naples, Italy, well strikes the key-note of this error, when he says (*Med. Press and Circular*, Feb. 25, 1891, p. 195): "It is painful to see these men carried away with this enthusiasm of Koch's fluid when they know that such a wide gulf exists between theory and practice, and when the very laws of scientific pharmacol-

ogy and rational therapeutics are violated. The mistake exists in neglecting to see the gulf that lies between the laboratory and the clinic where all such fine dreams are blasted."

I am free to say that the mortification of professional pride, and the shock to public confidence recently perpetrated in the name of a specific cure for consumption, would all have been saved if we had raised our standard of treatment higher than the walls of the laboratory, and planted it on the solid and rational ground of practical experience.

I am not unmindful, however, that those who indorse the contagion theory claim that aside of experiments on animals, there is ample clinical evidence to justify their belief. Let us briefly examine these claims. Their chief argument is the work of Cornet, who investigated the death-rate from consumption among the nursing members of the Catholic convents and monasteries in Prussia, and found that this disease causes 62.88 per cent of all their deaths (*Zeitschrift für Hygiene*, vol. vi, p. 65). This is, indeed, a high death-rate, but it does not demonstrate the contagious nature of consumption. It merely shows, what was well known before, that this disease prevails largely among those who lead indoor and confined lives. According to Dr. Baer's research (*Ueber das Vorkommen von Phthisis in dem Gefängnissen*, 1884) the death rate from consumption among German prisoners is greater—ranging from 64 to 90.9 per cent. Another point which destroys Cornet's conclusions entirely, is forcibly brought out by Dr. Baer's statistics. These show that prisoners who suffer solitary confinement, and who have, of course, no personal contact with any outside sources of the disease are more vulnerable to consumption by 20 per cent. than those who are allowed to associate with each other.

Another argument is that houses in which consumptives died are centers of infection. This is principally based on the research of Dr. Flick, who believes from his investigations, that 20 per cent. of the houses in the fifth ward of the city of Philadelphia are so infected. It is interesting to observe, however, that Dr. Flick's conclusions are not corroborated by other observers equally competent who have studied the question of house infection. Dr. Langerhans, who practised medicine for nine years in Madeira, an island which is visited every winter season by about 400 consumptives, states (*Zur Aetiologie der Phthisis*, Virchow's Archiv. 1884, vol. 96. p. 289) that these invalids are



lodged, boarded, and in great part nursed by English colonists, varying from 210 to 250 in number, who live in about 100 houses. The rooms which are occupied by consumptives in the winter, are reoccupied by the resident families during the summer—thus insuring the closest intermingling of the well with the sick. House infection should certainly make its influence felt here, but the health records which have been accurately kept since the year 1836, show that only four of the English colonists died from consumption during all this time, and that one of these suffered from the disease before he came on the island.

Dr. Adams, of Colorado Springs, states in a private communication to me, that Colorado Springs has been a health resort for about seventeen years, and comprises about 11,000 inhabitants, and that the majority of the rooms in the boarding houses are, and generally have been constantly occupied by consumptives. Yet, after a diligent search among the physicians of that place, some of whom resided there from the first, he could only find a record of seven cases of consumption which originated there during this time; and so far as he could ascertain, none of these were especially exposed—at least none were husband, wife or sister who had charge of another consumptive.

Dr. Haupt, one of the resident physicians of Soden—a beautiful watering resort for consumptives, in Germany, says that there are one hundred and one families, whose members with the aid of servants, lodge and nurse consumptives and other invalids during the summer seasons. During the winter the same rooms are reoccupied by the members of the landlord's families. This has been going on for 33 years, and during this time there were exposed to this contagion, if so it may be called, 653 persons, fifteen of whom died from consumption, but in most of these the source of the disease was traceable to inheritance, to colds and exposure, but none of them to contagion.

Now when these facts are connected with other well known facts, such as the statistics of the Brompton Hospital for Consumption in London, and the Friedrichshain Hospital in Berlin, which fail to show a single case of contagion among 262 physicians and clinical assistants, and 1017 nurses—the former during 36 years and the latter during 16 years; the declaration of Dr. Detweiler, that during 14 years not a single case of consumption was contracted among the nurses and employees in his hospital for consumptives at Falkenstein; or the fact that among a

collection of sixteen hundred and twenty-six cases of consumption among married people (for particulars I refer to my address on Hygiene published in last year's Transactions of this Society) the same disease existed in both couples only in 44 instances. I think no further proof is needed to demonstrate that consumption is not propagated from person to person through contagion.

I hope I shall be the last one to deny to my colleagues on the other side, the same honesty and conscientiousness of purpose as I ascribe to myself; but should this make me willing to brush aside this weighty mass of clinical testimony which is diametrically opposed to the contagion doctrine, and to accept as my guide, principles of treatment which are conceived in theory and born of fancy, and which have nothing to support them in bedside experience? He who has been a diligent observer during the last ten or fifteen years, must be aware by this time that every specific measure which has been proposed for the cure of consumption, from benzoate of soda, and hot air inhalations to tuberculin, has been a dismal failure, in spite of the fact that they have all been shown to possess strong anti-bacillary powers. Glance at the beggarly results which have been obtained from tuberculin. According to recent official reports,<sup>1</sup> fifty-five in number, issuing from the clinics, polyclinics, and pathological institutes of the Prussian University, only about one per cent. (10) of 932 consumptives, who received the specific treatment were cured. This is, indeed, a very diminutive proportion of cures when we reflect that all but one of the latter were in the first stage of the disease. There cannot be the least question that so far as the treatment of consumption is concerned, the bacillus theory leaves the profession exactly on the same level which it occupied ten years ago. Not only did it not advance the interests of pulmonary therapeutics, but it deflected research into channels of error, and served as a barrier to an investigation of the true causes of consumption.

Let us now relinquish the gloomy side of this picture and turn to the hopeful experiences of those who practically disregard the teachings of the bacillus theory, and treat the disease according to its clinical indications. First of all I shall refer to the experience of the late Dr. Brehmer in his world renowned institution at Görbersdorf, in Germany. In 1887 he gives the statistics of

<sup>1</sup> *Die Wirksamkeit des Koch'schen Heilmittels gegen Tuberculose.*

150 cases of consumption which he treated, 12 of whom were in the first; 80 in the second; and 58 in the third stage. Of these, 15.3 per cent. were cured, and 11.3 per cent. in whom the disease was arrested. Of those in the different stages he cured 50. per cent. in the first, 20. per cent. in the second, and 1.7 per cent. in the third stage of the disease.

In 1888, he gives the statistics of 554 cases which he treated, of whom 49 were in the first, 310 in the second, and 195 in the third stage. Of those in the first stage he cured 36.1 per cent., in the second, 9.7 per cent., in the third, 0.5 per cent.

The results reported in the Sixth Annual Report of the Adirondack Sanitarium, under the supervision of Dr. Trudeau, are not less encouraging. Fifty-two patients were treated in the following stages: 21 in the first, 18 in the second, and 13 in the third. Of those in the first, 13 or 61.90 per cent.; in the second, 2 or 11.11 per cent.; in the third none were apparently cured<sup>1</sup>—showing a total of 28.84 per cent. cures. Besides these it is shown that there are 11 cases, or 21.15 per cent, in whom the disease is arrested, that is, in whom all constitutional disturbance has disappeared for several months, but in whom the bacilli, cough and expectoration are still present. It may not be too much to hope that a number, and possibly most of the arrested cases will in time go to swell the list of the cures.

Similar favorable testimony concerning the non-specific treatment of consumption is also attested by other institutions of a like character, notably by that of Dr. Detweiler, of Falkenstein. In fact such institutions demonstrate that the successful treatment of pulmonary consumption is no longer to be disputed, and they show that no chronic medical disease is so amenable to treatment as pulmonary consumption.

A most interesting point in this question is the fact that there is a consensus of opinion as to the methods which bring about the best results in the treatment of this disease. The first is an institution in which the patients are under the immediate and direct supervision of intelligent physicians and nurses. In regard to these Brehmer in no uncertain tones says (*Therapie der Chronischen Lungenschwindsucht* 1887, p. 93), "Special institutions for the treatment of consumption give the greatest promise of

cure." Dr. Trudeau states (*Transactions of American Climatological Assoc.*, 1889, p. 168), "If anything is to be done for those who are both poor and consumptive, it cannot be done outside of an institution." Many other physicians who have had experience of this sort are equally emphatic in their opinion on this subject.

The second is rest, or at least a rigid control of the physical movements of patients. On this subject Brehmer says (*Mittheilungen aus Dr. Brehmer's Heilanstalt*, 1889, pp. 43 and 45.) "This much I can assert that all fatigue is an injury and a poison to the consumptive. \* \* \* The healthy individual rests because he is tired, but the consumptive must rest so that he cannot become tired."

One of the important instructions in Dr. Trudeau's Sanitarium is, "When feverish, patients will do well to make as little exertion as possible. Fatigue, when induced in persons still having active disease is sure to be followed by loss of appetite, fever, exhaustion, and even sweating." (*Trans. American Climatological Assoc.*, 1889, p. 174.)

Dr. Detweiler, in his report for 1886, states that every patient who is not confined to bed must repose in the open air on a reclining chair throughout the greater part of the day.

Dr. Volland, of Davos, who has had extensive experience in the high altitude treatment of consumption declares (*Die Behandlung der Lungen-schwindsucht im Hochgebirge*, p. 18) that rest in the open air is the first duty of the consumptive patient, and that, if he is able, he is allowed to sit out-of-doors, and if not, he is confined to bed in a well ventilated chamber.

This feeling to regard rest as such an important element in the successful management of consumption is not confined to these and other public institutions, but is also shared by private practitioners, and it is based on the sound pathological reason that consumption is not a local disease of the lungs, but one which implicates the whole constitution. A consumptive must be looked upon as one verging on physiological bankruptcy. His whole strength is already absorbed in the performance of the necessary functions of life, frequently carried on imperfectly. His digestion is weak, his bowels may be disordered, sleep is restless and disturbed there is a waste of tissue owing to the fever, and his muscular power is impaired to such a degree that a short walk or a small amount of physical exercise saps his strength, and may wholly disable him. Yet strange and paradoxical as it seems, weak as he is,

<sup>1</sup>By apparently cured is meant when the rational signs of the disease and the bacilli have been absent for at least three months. I think it is but reasonable to assume that such cases are cured.

he persists in the belief that exercise is the one thing needful for his restoration. This feeling is not confined to consumptives, but lives in behalf of a strong public sentiment. It is builded on the knowledge that in health exercise gives strength. But what an enormous difference between the body in a normal state, and when suffering from a chronic wasting disease like consumption! The two conditions may be illustrated by comparing a business man who is threatened with insolvency with one whose credit is good. If the former pays out as much as he takes in, his finances will always be in a crippled state, and he will be in constant danger of going to the wall; but if he halts—that is, if he diminishes his expenses and maintains or increases his income—his capital will accumulate, and in time he will be able to compete with other capitalists. But the business man whose credit is unimpaired goes on and invests all his surplus capital—that is, he exercises his financial strength to the utmost limit of prudence—and thereby enhances and improves the integrity of the institution which he represents. So it is with the taking of exercises. If this is to be beneficial, a certain amount of strength must be possessed by the individual before he begins it, and by putting this strength to proper use it will grow and accumulate; but he who has no, or very little strength at the outset, must reduce his expenditures, or his waste, and enlarge his income, or else go into physiological bankruptcy. We must realize that with the consumptive, it is wholly a question of constitutional resistance; that when he is weak the disease is strong and advances; that when he is strong the disease is weak and recedes; and that the force which he expends in performing exercise deducts so much from his total vitality, and allows so much less for the body to cope against the disease, and to perform the essential functions of life.

Moreover, there is a perfect agreement in these institutions in regard to the great utility of supplying nutritious food in the most concentrated form; of reducing high temperature with antipyrin, phenacetin, and antifebrin; of checking the waste which is occasioned by cough, expectoration, sweats, and diarrhoea; of employing pneumatic and climatic treatment; and in fact of everything which goes to enhance the vigor and vitality of the body.

I think I am justified in saying that hard, cold, positive facts are the best crucial tests to which a theory can be submitted in

order to ascertain its correctness. The specific cure for consumption is utterly condemned, when compared with the general treatment of this disease on such a basis. How would mercury rank as a specific in syphilis, or quinine in ague, if their curative results were as hapless as those of tuberculin? Even if a specific cure for consumption were possible, it is difficult to see its need in view of the large number of cures, as I have shown, are annually made by other means. From my own personal experience, I can testify that there is no chronic disease which responds more readily and more promptly to persistent and well directed general treatment than pulmonary consumption; and there is no reason to doubt that with the advance of the scientific study of the disease the percentage of cures will increase. A specific cure for consumption is not of so much consideration now as a study and a development of the lines of treatment which have been shown to hold out such a magnificent measure of enduring success.

One more thought and I am done. Ever since the failure of tuberculin became generally palpable, there arose a feeling in the minds of many of his followers, that Dr. Koch had made a serious mistake in the practical application of his theory, and that eventually great therapeutic results are bound to flow from it. Dr. Koch is not in error, but is more consistent than many of his disciples who follow him in the distance. He has a logical belief in his theory, and knows what the practical application of tuberculin implies better than any other living being. There cannot be the least question concerning his ability to cure by inoculation, the disease which he artificially induced in animals; and if consumption in man were caused through contagion or inoculation, or was of the same nature as the disease which he produced in animals, it would be perfectly reasonable to hope that he could cure the consumption in the human family. But the disparity which exists between that which *is* and that which *seems*, is a vortex which has stranded and annihilated many an idea. This is not the first time that the contagion theory of consumption has come to grief. A century ago the government of Naples concluded that consumption was an infectious disease, and practised the most rigorous isolation of those who suffered from this disease, for more than fifty years. The results were abominable. Reliable historians inform us that besides causing untold misery, these laws were not



of the slightest service in diminishing the death rate from this disease.

Should we not profit by these dearly bought experiences? Is it not high time that we take an account of our bearings and begin to recognize that he who hugs the delusion that consumption will be cured or prevented through the miraculous operation of some anti-bacillary agent or process, will only live to reap "from the hopes which around him he sows, a harvest of barren regrets?"

THE ELECTRICAL TREATMENT OF FIBROID TUMORS—WITH AN ANALYSIS OF FORTY-SIX CASES. \*

BY G. BETTON MASSEY, M. D.,

PHILADELPHIA.

The progress of the Apostoli method of treating fibroid tumors of the uterus presents both analogies and contrasts to those of some of the recent therapeutic claims that have been widely investigated by the medical world. Recognized at last owing to the persistent agitation of its originator, it was, like the Brown-Séquard and Koch remedies, enthusiastically adopted by those pioneer advocates who often make up for crudeness of training and inexactness of observation by a debt of stimulated progress laid upon subsequent workers. In contrast to the theories alluded to, it has since borne the test of capable experiment to an extent that even exceeds the original claims, and with the broadened use of electricity in other allied conditions, has made a new departure in gynecology. Unlike them, also, it has encountered an opposition of unparalleled fierceness, an opposition, nevertheless, that has been as healthy as it has been fierce. The cause of this unusual attitude towards a new remedy is easily seen in the recent extension of abdominal surgery, and this highly favored disease has heretofore been treated to a rivalry of methods that cannot be other than productive of the best results. Far from regretting this rivalry, I indeed point to it as an important index of medical development, and cannot but regret that other therapeutic efforts now blindly accepted are not subjected to similar tests. I do regret the intemperate statements of certain extreme opponents. Undermined in their wholesale and indiscriminate resort to dangerous operations by the attention bestowed upon a milder and non-dangerous method of enforced atrophy, they have been invariably

the aggressors in controversy, condemning in unmeasured terms a method of which they knew nothing. This is in striking contrast to the position of electro-therapeutists, who willingly concede to surgery certain cases unsuited to electrical treatment yet demanding active help.

Experience is alone the final arbiter, and in view of the many cases of symptomatic cure and reduction, and the considerable number of those who that have disappeared under electrical treatment, now on record, it is in order for those who advocate an exclusively surgical treatment to come forward, not with wet specimens just removed from patients who may die subsequently, nor even mere reports of recoveries and deaths from the operations, but with full reports of the ultimate results in each case that withstood the operation of oophorectomy and hysterectomy. The profession is not simply interested in the average mortality of these operations for comparatively benign tumors, but wishes to know also the results in the restoration of health and comfort to these patients. For instance, some careful operator should tell us how often removal of the appendages for bleeding myomas fail to control the hæmorrhages; how often this procedure in patients approaching the menopause is followed by mental disturbance; how often a successful hysterectomy is followed by abdominal fistulas, intestinal adhesions, hernias and other sequelæ that are as troublesome and painful to the patient as the benign tumor itself had been. Until such statistics are collected there can be no true comparison of surgical and electrical methods, as the latter refer only to results that are always more or less remote from the remedial procedures.

As an illustration of the results of electrical treatment of these growths I have analysed the histories of forty-six cases treated consecutively by myself, in which I have considered the conditions present at the beginning of treatment, the nature of the treatment, and the results as ascertained at various periods after the cessation of treatment.

A study of these cases will show that seven cases should be eliminated from consideration in this paper because two were polypoid and their delivery per vaginam was merely assisted by the electrical applications made, and five were treated for so short a time or were so soon lost sight of that it is impossible to use them in demonstration.

This leaves thirty-nine cases that had more or less thorough treatment and in which the results have been ascertainable. These are

\* Read in the Obstetrical Section, American Med. Assoc., May 7, 1891.

divisible into five classes in the matter of results attained:

Class I. Cases of complete anatomical and symptomatic cure, the tumors disappearing and the patient being restored to health. Of this class there were five cases.

Class II. Cases in which the tumor was considerably diminished in size and all other symptoms were cured. Of this class there were twenty-three.

Class III. Cases in which the tumor was not diminished in size but all the symptoms were relieved, or in which the tumor was reduced but the symptoms were not relieved. Of this class there were eight.

Class IV. Cases in which the tumors were not diminished nor the symptoms relieved. Of this class there were two.

Class V. Cases made worse by the treatment. Of this class there was but one.

#### PERCENTAGES.

Based upon the thirty-nine cases of thorough treatment, therefore, it will be seen that 12.8 per cent. resulted in a complete cure and disappearance of tumor; 79.4 per cent. in symptomatic cure with or without reduction in size; 5.3 per cent. were unaffected; and 2.5 per cent. were made worse. Omitting the case that was made worse since it was fibro-cystic and should not have been treated, the successes amount to 95 per cent. and the failures to five.

The prevalence of the several varieties of tumor in the series is shown in the following table:

	Intra-mural.	Intra-mural and sub-peritoneal.	Subperitoneal.	Submucous
I. Complete disappearance.	5			
II. Symptomatic cure and reduction.	15	3	4	1
III. Symptomatic relief without reduction.	6	1		1
IV. Unaffected by treatment.			2	
V. Made worse.				1

#### THE FAILURES.

Of the two cases unaffected by the treatment, one was that of a patient who had two painless, movable, subperitoneal growths attached to the uterus by long pedicles. There was absolutely no symptom whatever of these tumors, beyond the mere fact of their physical presence, and as they were not situated favorably for electro-puncture and were giving no trouble anyway they were left alone, after a thorough trial of mild intra-uterine applications. No. 33 was a large, kidney-shaped subperitoneal tumor attached to the anterior surface of the

uterus and lying between the latter organ and the bladder. As the bladder was spread out in front of it, preventing puncture, resort was had to long continued vaginal galvanic alternatives. Under these the tumor was released from the pelvis, but the patient was not sure that she felt any better.

The case made worse was No. 3, a large intra-uterine fibrocyst which was treated before it was pointed out by Apostoli that this form was liable to be made worse by electricity. The death from septicaemia did not occur until sometime after the cessation of treatment and during attempts to extract the mass surgically by piece meal. The case resembled closely the one described by Emmett at page 587, of his work on the Diseases of Women, in which it is stated that death also occurred during attempts at extraction. Though sent to me by an expert surgeon my own case would have been far better treated by hysterectomy than by any form of electricity.

#### METHODS.

It will be noticed that six cases were treated by puncture. The greater number of these punctures were of the kind that has been designated as "buried"—a variety of puncture that was originated by myself, and one that I think more powerful and safer than that described by Apostoli. Unlike the Apostoli needle, which is only insulated by a movable sheath up to the point at which the puncture is made, my own needle is insulated by vulcanized rubber to within one centimeter of the end, with a view of preserving the track made by it through healthy tissue from an electrolytic softening that would prevent immediate union. Punctures made in this way have been proven by me to heal in three days in spite of the use of 150 ma. at the point within the fibroid tissue, while the older form of puncture usually remains unhealed for a week or more.

No unpleasant reactions followed any of the punctures, which were sometimes exceeding an inch in depth, and while I do not think that any but those skilled in it should attempt this method, I do not hesitate to employ it myself in those rare cases that are adapted to it. None of the cases in which the tumors disappeared were punctured, but this was merely because their intra-mural situation neither required nor permitted it.

The intra-uterine method is certainly the method of choice, and with gentleness, and especially the use when possible of the

elastic electrode devised by me, is free from risk in all cases except those complicated by acute inflammatory conditions. I have been disposed of late to increase the intervals between these applications to five or more days, interspersing one or more vagino-abdominal treatments for their contracting effect.

The vagino-abdominal galvanic alternatives that have been advocated by Danion of Paris have a considerable value when neither of the two better methods are available. I have seen reduction occur during the use of this method in several cases, and can testify to its power over inflammatory conditions in the pelvis.

As will be seen from the notes of some of the cases, persistent treatment has at times, been the keynote of success, though the best results were often attained in a short time.

### SOCIETY REPORTS.

#### NEW YORK NEUROLOGICAL SOCIETY.

*Meeting of May 5th, 1891.*

The President, Dr. L. C. Gray, in the Chair.

*The Back in Railway Spine.*—Dr. F. X. Dercum, of Philadelphia, read a paper with this title. He said that it seemed to him in discussing railway injuries, the physical condition of the back had not been sufficiently dwelt upon. It was certain that more had been said pro and con upon injuries of the spinal contents, and far more still upon the subject of traumatic neuroses. It had been the speaker's fortune to examine a large number of railway and allied injuries, and it had appeared to him, that the condition of the back was often poorly understood and often unappreciated, while important points were sometimes entirely overlooked. Further conditions were occasionally observed which were difficult of explanation, and it was to these he wished to call attention. It was well known that pain of various kinds was met with in railway cases, but he wanted to exclude from the discussion all pains, the existence of which could not be confirmed by any physical evidence and which rested solely upon the unsupported statements of the patient. On the other hand all pain, signs of which were evoked without previous warning or suggestion should be rigidly admitted. He strongly advised the thorough examination of all such patients by superficial and deep pressure and by blows, as by this means information of decided character, might be

gained in cases otherwise obscure. Another important method of test was by motion. In regard to pain elicited by voluntary motion, the objection might be urged that here an opportunity was presented to the malingerer. There were, however, so many other means of ascertaining the truth that difficulty in arriving at definite conclusions would rarely be experienced. Much depended upon the manner in which the various tests for motion were applied. These tests consisted of flexion forwards, lateral flexion, torsion and transmitted shock. Having first practiced palpation and pressure, and gleaned such information as could be obtained from these sources, with the patient standing before us the back should be closely inspected. Following this the tests for motion should be gone through. After having briefly considered the various tests for eliciting pain, he said that not only was it possible with due care to settle the question of the genuineness of the symptoms by any one of the methods detailed, but it was also evident that there must be a general correspondence in the results of all the methods. We should expect for instance that the area of pain upon deep pressure would correspond, other things being equal, to the area of pain on motion, or that the region of pain elicited by percussion would correspond to the region of pain elicited by transmitted shock. The speaker then detailed the histories of six cases bearing upon the question. The various symptoms presented by these cases could be conveniently grouped as follows: first, those due to the physical condition of the back; secondly, the symptoms of functional derangements and asthenia; and, thirdly, those that presented psychic and hysterical symptoms. To the first group belonged: first, pain on deep pressure; secondly, pain on motion and transmitted shock; thirdly, muscular spasm and rigidity; fourthly, muscular weakness. Now the pain elicited by pressure, motion, or shock, was evidently the result of a deep seated injury, either to the ligaments of the spinal column, or to the muscles, probably to both. Practically, it was impossible to differentiate between the two, nor was it important to do so. To muscular spasm and rigidity were to be assigned the same value which was assigned to the muscular spasm observed in a sprained, dislocated or broken limb. The muscular weakness resulting occasionally in lordosis, was to be ascribed to the general weakness resulting from the shock, and also to the direct effect of the trauma upon the muscles themselves. To



the group of symptoms of functional derangements and asthenia, belonged the various symptoms of general weakness, both mental and physical, tremor, sweating, inability to properly expel or to retain the urine, etc. To the group of psychic and hysterical symptoms was relegated the hypochondria, the night horrors and the convulsions. One important problem, however, still presented itself, and that was why it was that some of these cases did not attain their maximum severity for days and weeks after the accident. It was thought exceedingly probable that there was a direct extension of inflammation from the original site of the trauma along the sheaths and tendons of the muscles. It was difficult to escape from this inference, inasmuch as there was a marked spread in the area of pain on deep pressure. Hand in hand with this, there was, beyond doubt, a radiation in the muscular spasm, a radiation too which might reach not only muscles immediately adjacent, but those even relatively remote, such as muscles of the abdomen or of the shoulder. As to the question of duration of the symptoms it was impossible to give a definite answer. It was a question of probability, and of degree, and therefore one in which legitimate differences of opinion might obtain; however, taking the cases the speaker had seen, it was evident that chronicity must be admitted as established beyond cavil. In regard to the disappearance of so-called "litigation symptoms" made so much of by Page and others, the speaker's observations had been that when a claim for damages had been settled, the mental condition improved very much. A man who perhaps was poor, was suddenly raised to a condition of relative wealth. No wonder that hypochondria often disappeared and was replaced by buoyancy and exaltation, it would be strange indeed if it were otherwise. After a while, however, he had seen the old mental condition partly re-establish itself, while the physical condition had undergone no change save that which could be accounted for by the slow repair of time. Lastly, the cases which had been presented were selected because of the marked and pronounced condition of the back. He did not wish to create the impression that every case should present the back symptoms to an equal degree in order to be considered genuine. As a matter of fact, in a large number of instances of *bona fide* railway back, the symptoms were far less evident than in the cases detailed. Finally

he repeated that careful application of the various tests for eliciting pain and spasm could not fail to evoke a reply if trauma be really present.

Dr. G. M. Hammond called attention to a train of similar symptoms to those described by Dr. Dercum to be found in a modified form among athletes. This was especially the case with those who practiced jumping and running. He had seen several instances in which the patients complained of pain in the back and deep seated pain on pressure, and on stooping forward. There would also be exaggerated reflexes. These symptoms would persist for months while the individual was practicing his exercises. In jumping the foot struck the ground in the take-off with considerable force. In running long distances the repeated jar from the foot striking the ground would be transmitted to the spinal cord. Indeed it was his opinion that the symptoms he had met with were due to long continued transmitted concussion to the cord. After examining a great number of athletes he had invariably found that the knee-jerk was exaggerated, particularly among those who ran and walked.

Dr. E. C. Spitzka referred to some practical features of the paper and particularly to the tests used to locate the sprain. Conclusions drawn from a large number of cases were contradictory and the matter to a certain extent still obscure. Lateral flexion and torsion and transmitted concussion were of the utmost value. Within a year the speaker had seen one case of almost fatal collapse from severe transmitted concussion. The spinal deformity was often very slight and escaped observation while producing serious nervous symptoms due to slow hypertrophic changes.

Dr. A. D. Rockwell said that concussion of all kinds might be immediately followed by complete paralysis. When he was surgeon in the United States Cavalry in the late war, one of the men was injured while his horse was jumping a ditch. There was complete paralysis at once, the man being carried for several days in an ambulance. Partial recovery gradually took place. The speaker saw the man again a short time ago learning that he had always been more or less of an invalid, suffering from pain in the spine on pressure, melancholia and neuralgic symptoms. This condition had been present ever since the time of the injury. As to the treatment of cases such as the author had described he thought that the

actual cautery when properly applied gave the best results. He had used it in the instance narrated with direct benefit.

Dr. Dercum thought the tendency was to look for some other cause for these symptoms, other than the right one. If the physician would examine the spinal columns more carefully in patients complaining of the symptoms he had described diagnostic points would usually be determined.

### SELECTED FORMULÆ.

#### FORMULA FOR WHOOPING COUGH.

Talamon, in the *Méd. Moderne*, gives the following formula for whooping cough:

<b>R</b>	Terpini hydrati.....	1.0-1.5 grammes
	Antipyrini.....	1.0 gramme
	Syr. aurant. cork.....	50.0 grammes
	Aquæ Tiliæ.....	60.0 grammes

M. et. Sig. One-half to one teaspoonful frequently during the day, for a child from one to four years of age.

#### ANTI-DYSPEPTIC POWDER.

Dujardin-Beaumetz, in the *Union Méd.*, gives the following formula, which he calls an "anti-dyspeptic" powder:

<b>R</b>	Maga. sulph.....	
	Cret. præpar.....	
	Calc. phosphor.....	10.0 grammes

M. et. div. in chart No. xl.  
Sig. One powder before meals.

#### NITRATE OF SILVER IN CATARRHAL ICTERUS.

Dr. Niecechi, in *Medicina*, claims that nitrate of silver is specific in catarrhal icterus, checking all symptoms immediately. He gives the following formula:

<b>R</b>	Arg. nitr.....	0.06 gramme
	Aquæ dest.....	180.00 grammes

Sig. One tablespoonful three or four times a day. The dose may be repeated if not efficacious. A rigorous anti-catarrhal diet should be enforced.

#### SUMMER DIARRHŒA.

<b>R</b>	Resorcin.....	gr. iss.—gr. iij
	Infus. chamomil.....	ounces ij
	Tr. opil.....	gtt. ij
	Tr. cascarill.....	gtt. xv

M. Sig. Teaspoonful every two hours.

—*Kinder-Arzt.*

#### PILLS FOR DYSENTERY.

The following pills used in the treatment of dysentery have given satisfactory results:

<b>R</b>	Powdered ipecac.....	gr. iv
	Calomel.....	gr. jss
	Extract of opium.....	gr. j

Make into three pills, and give one each hour, in the treatment of diarrhœa or dysentery due to exposure to heat.

—*Medical News.*

#### APHRODISIAC PILLS.

According to the *Journal de Médecine de Paris*, Lutaud employs the following for the purpose of producing sexual stimulation:

<b>R</b>	Powdered nux vomica.....	¾ grain
	Bromide of iron.....	15 grains
	Phosphorus.....	¾ grain

Excipient a sufficient quantity.

Make into twenty pills and take one each night.

In addition to this treatment the patient should resort to hot and cold douches and gymnastic exercise, massage, and systemic tonics, and frequently coca will be found of value, as in the opinion of Lutaud this drug possesses very distinct aphrodisiac powers.

#### SALICYLATE OF MERCURY.

This remedy is one which has been largely neglected, despite the fact that it is useful to a high degree. One of the great drawbacks which attended its use was the impossibility of dissolving it in water without the addition of alcohol or of chloride of sodium. Otherwise this salt has antiseptic powers equal to corrosive sublimate, and is devoid of the latter's bad qualities. M. Vacher has overcome the difficulty of making a solution (*Medicine Moderne*) by obtaining salicylate of mercury through the double decomposition of a mixture of corrosive sublimate and salicylate of soda in water. In addition to the salicylate of mercury, a chloride of sodium is formed which makes the solution a stable one. This solution is not irritating, contains no alcohol, and may be used for various purposes according to its strength.

For external use the following formula may be employed:

<b>R</b>	Hydrarg. bichlorid.....	gr. iv
	Sodii salicylat.....	gr. viij
	Aquæ.....	oz. viij M.

If a weaker solution is desired, the following way be ordered:

<b>R</b>	Hydrarg. bichlorid.....	gr. j
	Sodii salicylat.....	gr. ij
	Aquæ.....	oz. x M.

For hypodermic injections in the treatment of syphilis, M. Vacher injects one cubic centimeter of the following solution, which has given him the best results:

<b>R</b>	Hydrarg. bichlorid.....	gr. v
	Sodii salicylat.....	gr. x
	Aquæ destillat.....	oz. j M.

One cubic centimeter contains three-twentieths of a grain of salicylate of mercury. The injection is not painful, and is never followed by abscess. Internally, a table-

spoonful, or slightly more, of a one to a thousand solution may be administered.—*St. Louis Med. and Surg. Journal.*

#### ointment for ECZEMA.

$\mathcal{R}$	Thymol.....	'30 grains
	Oxide of zinc, } of each.....	6 drachms
	Starch,.....	
	Lard.....	1½ ounce

Apply twice a day to the affected part.

—*Journ. de Méd. de Paris.*

#### WHOOPIING COUGH.

For use at time of the paroxysm, Wilde recommends the following mixture, a teaspoonful of which is to be poured upon a compress and cautiously held near the child's mouth:

$\mathcal{R}$	Chloroformi.....	f 3 j
	Æther. sulphuric. purif.....	f. 3 ij
	Ess. terebinthinæ rect.....	f. 3 iiss

—*M Union Médicale.*

#### FOR EXTERNAL HÆMORRHOIDS.

Washing them with a solution of corrosive sublimate the strength of 1 to 1,000 or of carbolic acid, 1 to 50. After this the following salve may be applied:

$\mathcal{R}$	Iodoform.....	grs. v
	Extract of belladonna.....	grs. viij
	Vaseline.....	3 j

#### SUBINVOLUTION OF THE UTERUS.

Professor Barton Cook Hirst, of the University of Pennsylvania, recently gave the following as the best combination to use:

$\mathcal{R}$	Strychninæ sulphatis.....	gr. 1-20
	Quininæ sulphatis.....	gr. ij
	Extract ergotæ.....	gr. j

M. ft. pil. No. 1.

Sig.—At one dose. To be repeated thrice daily.

#### UTERINE WAFERS.

$\mathcal{R}$	Hydrarg. bichlor.....	gr. 1-16
	Sulphate zinc.....	grs. v
	Sub nit. bismuth.....	grs. xv
	Pulv. gum arabic.....	grs. v
	Carbolic acid.....	grs. iij

M. Pulverize the zinc; then add the rest of the ingredients, with q. s. water to make into a conical shape for a vaginal suppository.

This formula is offered to the profession as practically duplicating the Micajah medicated wafers. This formula, with the exception of the bismuth and acacia, has been used by the medical profession for a long time for onychia, etc. U. S. Dispensatory, 12th edition, Wood & Bache, page 1,115; used by Drs. Perkins and Physick.

#### TREATMENT OF BALANITIS.

Dr. W. R. Chichester states that he has obtained good results from the employment of the following (*Med. Rec.*):

$\mathcal{R}$	Atropiæ sulphatis.....	gr. i
	Zinci sulphatis.....	gr. ij
	Acid. boracic.....	gr. v
	Aquæ destillat.....	3 j

M. Sig. Apply two or three times a day with a brush.

He further states that this is open to any modification which the case suggests.

#### OX-GALL.

The following prescriptions containing ox-gall are recommended:

$\mathcal{R}$	Fellis bovis purificati.....	
	Magnesi carbonatis.....	aa c.
	Ol. menth. pip.,.....	mij.

M. et ft. capsulæ No. xx. Sig., a pill three or four times a day, after meals. Use in dyspepsia and constipation.

$\mathcal{R}$	Fellis bovis purificati.....	3j
	Ext. nucis vomicæ.....	gr. i
	Aloini.....	gr. j
	Ol. cinnamomi.....	mij

M. et ft. pil. No. xx. Sig., two pills between meals. Serviceable in torpor of the liver and in dyspepsia.

—*Med. Rec.*

#### INFANTILE CONVULSIONS.

$\mathcal{R}$	Choral hydratis.....	gr. iv
	Poussii bromidi.....	gr. viij
	Aquæ.....	
	Syrupi.....	aa.

M. Sig. One dose for a child æt. two.

—*Jacobi.*

$\mathcal{R}$	Pepsinæ.....	gr. xii to xxiv
	Hydrarg. chlor. mit.....	gr. ss to j
	Sacch. lactis.....	q. s.

M. et ft. chart. No. xii.

Sig. One powder every three hours after nursing.

$\mathcal{R}$	Ex. Pancreatis.....	3ss to j
	Hydrarg. chlor. mit.....	gr. ss. to j
	Sacch. lactis.....	q. s.

M. et ft. chart. No. xii.

Sig. One powder every three hours immediately before or after nursing.

—*Annals Gynecology and Pædiatrics.*

#### TREATMENT OF WHOOPING COUGH.

Löffler recommends the following solution to be used in the treatment of whooping cough:

$\mathcal{R}$	Freshly prepared chloride of silver.....	1½ grain
	Water.....	2 pints
	Hyposulphite of Sodium, a saturated solution.....	

Use by an atomizer, the liquid being directed into the pharynx. Repeat the application every two or three hours. This treatment is both prophylactic and curative.



# THE MEDICAL AND SURGICAL REPORTER.

ISSUED EVERY SATURDAY.

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The Editor will be pleased to get medical news, but it is important that brevity and actual interest shall characterize communications intended for publication.

## LEADING ARTICLE.

### INTRA-UTERINE STEM PESSARY.

During the past few years, very little has appeared in current literature concerning the intra-uterine stem pessary, and it is evident that its use is being more and more restricted. Not many years ago the stem pessary was regarded as an indispensable instrument in the treatment of certain forms of flexions and versions of the uterus. Now, it is equally true that to most of the present generation the instrument is known only by having seen a cut of it in a text-book. Introduced and abandoned by Velpeau, re-introduced and abandoned by Amusat, it was forced upon the notice of the profession by Simpson, in 1848. For twenty years it was lauded or condemned by gynecologists of prominence, but gradually experience in its use, and new discoveries in pathology have limited its field of application and demonstrated the dangers arising from its employment. Views upon the pathology of flexions have undergone a revolution, and the consensus of opinion to-day excludes the stem pessary in the treatment of flexions and versions.

In the treatment of atrophy of the uterus, and of the so-called infantile, or poorly developed uterus, with or without flexion, the use of the stem pessary, in connection with dilatation of the cervix, has its advocates. The stem pessary is advised also, especially by Wylie, to keep the cervix patulous after dilatation, and for the purpose of drainage. But inasmuch as the necessity for this procedure is felt only by a decided minority of operators, it may be assumed with safety that its omission would be a small loss.

Practically the stem pessary is used to-day for the treatment of the so-called infantile uterus, and of super-involution of the uterus—a very restricted field. The prognosis of super-involution of the uterus is notoriously bad; and when improvement does take place, it is usually but temporary. It is an open question as to whether super-involution of

the uterus is not equivalent to an early menopause. The infantile uterus is the result, as a rule, of a partial development of the sexual organs, and accompanies small ovaries—not infrequently cystic or cirrhotic—and small tubes. Menstruation in such cases is absent or imperfect. The reason why treatment directed to the uterus in such cases yield poor results is not far to seek. When, fortunately, the partial development is confined to the cervix or even to the uterus, and the tubes and ovaries are more perfectly developed, the prognosis is better. But in this field the stem pessary comes in competition with dilatation of the cervix, the use of electricity, and roborant medication combined with judicious exercise. It seems probable that the intra-uterine stem will continue to be used in certain cases of imperfect development of the sexual organs, not so much because of the positive good which its use will accomplish, but because this condition, when marked, is very rebellious to all treatment, and such unfortunate patients, especially when desirous of marriage, will demand that everything offering a reasonable hope of benefit shall be employed. But the practitioner must remember the teachings of the past, and warn his patient of the danger of salpingitis and peritonitis from the use of the stem; and be prepared at any time to see the poor prospect for sexual development, previously possessed by his patient, absolutely destroyed by the occurrence of serious pelvic inflammation.

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### CORRESPONDENCE.

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#### OUR INADEQUATE HOSPITAL FACILITIES FOR THE MANAGEMENT OF MILD CASES OF CONTAGIOUS DISEASES.

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TO THE EDITOR OF THE MEDICAL AND  
SURGICAL REPORTER.

Dear Sir :—I desire to relate a recent experience, not with the intention of fault-finding, but rather with the hope that benefit may result from its consideration.

On Thursday, May 14, I was called to see

a servant girl, Kate M., who, I was informed had been ailing since the previous Tuesday evening. Upon examination I found her to be suffering from a well-marked follicular tonsillitis, this being the eighth case of the kind I had seen in our square during the week. As she did not properly carry out the measures I suggested, and was rather troublesome to wait upon, the family, by whom she was employed, desired her removal. I accordingly arranged to have her admitted to the Philadelphia Hospital, as she said she could not afford to pay board anywhere.

Just as she was about to start for the Hospital, however, I detected for the first time, a profuse rash over her neck, breast, arms, legs and slightly on her face. There was no exacerbation of general symptoms, and my knowledge of her condition for the previous two days enabled me to conclude promptly that the eruption was not due to scarlet fever but to Rötheln. I so pronounced it, and had her conveyed, in the carriage hired by her friends, to the Philadelphia Hospital.

Upon arriving there she was refused admittance because of the contagious nature of her disease. Not having any place to go she had the driver bring her to my office for advice. Thinking it probable that a mistake in diagnosis had been made and scarlet fever suspected from the combination of sore throat and a rash, which certainly resembles the eruption of scarlet fever at times, I decided to accompany the girl to the Hospital, to make explanation, and accordingly had her taken there for the second time. Unfortunately the Hospital officials informed me that they could not receive a case of Rötheln and that the proper place for such a patient was the Municipal Hospital. We then proceeded to that institution where she was received and placed in a vacant ward, as I was particularly anxious that she should not contract a trouble more serious in nature than the one she had upon entering. After the arrival of the physician of the institution, after my departure, the case was diagnosed as scarlet fever, and she was placed in a ward with some patients who were convalescing from that disease. These facts I learned upon visiting her on Monday morning, about 36 hours after her admission to the Hospital. Examining her at this time I found her throat decidedly improved, no secretion in the follicles of the tonsils and the inflammatory action greatly subdued. The rash had disappeared. Temperature was 98° F., having rapidly come down from 102° F., which

was the record upon admission, and which I am quite sure was largely due to nervousness, as her temperature had been normal that morning.

So much was I impressed with the correctness of my original diagnosis, and so greatly did I feel the dangers she incurred from contact with her contagious surroundings, that I called upon the physician in charge of the Hospital and asked if she could not be removed to safer quarters. I was informed that even granting a mistake had been made by him in the diagnosis of the case it was not possible to do any better for the girl than keep her where she had been placed, that they did not have any room where cases of such mild contagion could be separately cared for, and that the nurse who would be obliged to wait upon her, had charge of cases of scarlet fever and diphtheria; and finally that as long as she had been for over 24 hours in the scarlet fever ward, she would not be apt to escape that disease by removal from the ward.

Whether this particular case is one of Rôtheln or of scarlet fever matters little as far as my purpose in this communication is concerned. While freely admitting my liability to err in diagnosis, I, however, feel justified in holding my original opinion respecting the nature of this girl's illness, and I also greatly fear that she will be the victim of a much more serious malady, due to her incarceration in a room poisoned by scarlet fever patients. Several questions have presented themselves as a result of this experience:

1st. Is it just to Philadelphia citizens that the city's Hospital for contagious diseases should have no ward or wards set apart for the reception of contagious diseases of such a mild character as Rôtheln, when patients may be cared for by nurses not on duty amongst cases of a more serious character?

2nd. Is it just to the physicians who may be obliged to do as I did and allow their patients to run the risk of contracting a more serious affection in the place they are confined for safety?

3d. Might not a physician be caused much annoyance if a patient felt disposed to prosecute him in case a more serious disease were contracted while at the Hospital?

It would seem that the claims of economy would demand better facilities for the management of the mild contagious diseases at the municipal Hospital, when we consider the relatively greater period of time patients must be boarded when afflicted with a grave

disease. Certain it is that the claims of humanity demand such attention.

Respectfully,

WM. A. CAREY,  
1947 North 18th Street.

ED. MEDICAL AND SURGICAL REPORTER.

Dear Sir:—Will you or some of your readers please give through the columns of your valuable journal, a remedy, or remedies to allay the itching following the hypodermic use of morphia, and oblige. Yours,

R. C. SPEAR, M. D.,  
Mt. Gilead, O.

ED. MEDICAL AND SURGICAL REPORTER.

Dear Sir:—Speaking of Hydrogen Peroxide; I used it recently to wash out a foul suppurating abscess in the roof of the vagina, after previously cleansing it with a bichloride solution. The abscess held about half a teacupful of pus, and had been existent for twenty years. Result was complete cure after one application.

WM. H. BURR, M. D.,  
Wilmington, Del.

## BOOK REVIEWS.

BLAKISTON'S QUIZ COMPENDS. A COMPEND OF DISEASES OF CHILDREN, ESPECIALLY ADAPTED FOR THE USE OF MEDICAL STUDENTS. BY MARCUS P. HATFIELD, A. M., M. D., Professor of Diseases of Children, Chicago Med. College, etc. One colored plate. Phila., 1890.

This epitome of the diseases of children consists of the condensed annual course of lectures delivered at the Chicago Medical College by the author. The lectures in turn, the author states in his preface, were founded upon Dr. Ernst Kormann's "Compendium der Kinderkrankheiten," which was translated by him in coöperation with Dr. E. J. Doering, at the University of Berlin. The frontispiece consists of a very good colored diagrammatic sketch of the fetal circulation, which is a wise provision in a book intended "especially for the use of medical students." We believe the book is admirably suited to the requirements of students, being clearly written, and consisting chiefly of definitions and short explanatory passages. This arrangement enables the small size so valuable in a quiz-compend, while allowing the work to embrace all of the chief affections of childhood. It is an excellent synopsis of the diseases of children and as such we commend it to the students for whom it is intended.



ORIGIN, PURPOSE AND DESTINY OF MAN OR PHILOSOPHY OF THE THREE ETHERS. BY WILLIAM THORNTON. Boston. Published by the author, 1891.

In this little book of one hundred pages, the author continues the thoughts expressed in his "Rationalism in Medicine" published in 1885. This philosophical essay will not be of any use to the busy practitioner of modern medicine, since one of the conclusions reached, is, that all drugs now commonly administered are positively harmful to the organism, since according to the theory advanced by the writer, nothing should be given in disease except those substances which are normally found in the body. To those who are interested in philosophy, especially as it bears upon the science of medicine, this volume will be found worth a careful reading, particularly the chapters devoted to the "philosophy of the three ethers" and "how to make medicine a science." In fact the whole essay is written in graceful language, and the theories of which the author treats and applies to medical science, are extremely enticing. The writer also devotes a chapter to the subject of the immortality of the *Life*, which his philosophy separates from its "material environment." To thoroughly appreciate the *idea* of the book, it must be carefully perused, since space will not here permit even a clear synopsis of thought advanced.

KOCH'S METHOD TO CURE TUBERCULOSIS, POPULARLY TREATED BY DR. MAX BIRNBAUM. Translated from the German by Dr. FR. BRENDENCKE. Milwaukee, Haferkorn, 1891, pp. 95.

This brochure consists for the greater part of a popular résumé of our knowledge of the tubercular process in its various manifestations; its consideration of Koch's method of treatment is limited to the republication of Koch's first communication in the medical papers. There is little in the pamphlet that is not much better treated elsewhere; and the success of the translation is extremely doubtful from an English point of view, the failure to dispose of the many Germanisms rendering the text rather unpleasant to readers unaccustomed to such idioms.

Considered as a medical work it is worthless because of the unsoundness of many of its statements and the brevity of the consideration of important points. As a popular presentation of tuberculosis, it is about what might be expected from a writer who confounds lupus with ring-worm, as is repeat-

edly done in its pages. As a review of Koch's work in the treatment of the tubercular process, there is everything to desire, little or nothing to be found, as the pamphlet was published before Prof. Koch had announced the character of the matter he employs and its manner of manufacture.

## PERISCOPE.

### THERAPEUTICS.

#### THE THERAPEUTIC VALUE OF CETRARIN.

Cetrarin is the name which has been given to the active principle of Iceland Moss. The drug is one having several valuable therapeutic properties. Recent experiments show that it stimulates the stomach and also the intestinal peristalsis, it also increases the number of both red and white corpuscles in cases of anæmia, and, finally, acts as a tonic to the nervous system. Kobert, in the *Journal de Méd. de Paris*, April 19, 1891, states that he has found cetrarin of great value in cases of chloranæmia complicated with constipation and loss of appetite. The dose employed was 10 centigramme in any convenient vehicles.

#### SOZOIODOL.

The comparatively new antiseptic, Soziodol has already been brought to the notice of the readers of THE REPORTER some time ago. It will be remembered that its chemical name is bi-iodo-para-phenyl-sulphuric acid. It is obtained by the action of fuming sulphuric acid on bi-iodide of benzene, which is saturated with carbonate of lead and filtered. The lead salt is decomposed from the mixture by sulphuretted hydrogen, and the aqueous solution allowed to evaporate. The crystals which are then formed are those of Soziodol. The preparation contains 42% of iodine.

Recent investigations have confirmed the valuable antiseptic properties of this drug. It is similar, yet in many ways far superior to iodoform. Its odor is not unpleasant, and its healing properties more marked. Its action in tuberculous or scrofulous ulcerations is excellent, and it has been used with success in both gonorrhœa and syphilitic sores of the generative organs. A rapid curative action has also been seen to follow its use in various chronic cutaneous affections, in ozena, and in laryngitis. As in antiseptic in surgery, it is very useful,

promoting rapid healing, and keeping the parts free from infection. It may be advantageously dispensed in connection with starch, vaseline, or cerate.—*Journal de Méd. de Paris*, April 19, 1891.

#### TREATMENT FOR VARICOSE LEG-ULCERS.

Basing his opinion upon numerous experiments and a large number of successful cases, Dr. J. Braun, in the *Allgemeine Med. Central-Zeitung*, May 6, 1891, advocates most highly the treatment of leg ulcers with the following formula :

<b>R</b>	Zinci oxyd.....	15.0 grammes
	Lanolini.....	100.0 "
	Unguent. moll.....	40.0 "

M.

The ulcer should first be carefully washed and dried and the above salve, thickly spread upon a piece of linen, applied, and covered with a light bandage. The patient should be kept in bed. Almost immediately after application of the ointment all pain and itching will disappear, and the copious discharge will soon lessen.

According to Braun this salve forms a protective covering over the ulcer, and the lanolin absorbs the purulent discharge, while further suppuration is checked. The ulcer will therefore become dry and heal. In discolored ulcers the salve should be applied four or five times a day. In about three or four days the ulcerated surface will assume a healthy appearance and cicatrization will begin. The author has even seen deep and extensive varicose ulcers heal in this way, without any transplantation of skin being necessary. After healing, the author advises that an elastic bandage should be worn for some time over the seat of the ulcer.

This same salve has been found by Braun to be of great service in eczema, and as an application to any granulating surface. In eczema capillitii the addition of a little bichloride of mercury will be found excellent.

#### BROMIDE OF ETHYLENE IN EPILEPSY.

The *Münchener Med. Wochenschrift*, May 5, 1891, contains the description of a new anti-epileptic, reported by Dr. J. Donath, of Budapest. The remedy advocated is bromide of ethylene (æthylenum bromatum). The drug is of a light brown color and smells something like chloroform. Its taste is sweet, but it leaves a burning sensation in the mouth. At 0°C. it freezes to a snow-white crystalline mass, and it boils at 131°

C. Its specific gravity is comparatively high, being 2.163, at 21°C. Bromide of ethylene contains 90.9 per cent. of bromine. The fluid is insoluble in water, but is soluble in any proportion of rectified alcohol, and forms a perfectly clear solution in any of the fatty oils, such as oil of sweet almonds.

The drug is best given in the following 5 per cent. oily emulsion :

<b>R</b>	Æthyleni brom.....	5.0 grammes
	Ad. emuls. oleos.....	100.0 "
<b>M. Sig.</b>		

Thirty drops in a little sugar and water two or three times a day for adults. On the third day the dose should be increased to 40 drops; in three days again to a coffee-spoonful, then to a teaspoonful. In children from eight to ten years of age, the initial dose should only be 10-20 drops. The dilution of the emulsion in water or milk is necessitated on account of its irritating properties, and any gastric irritation is to be avoided. In patients with extremely irritable stomachs, gramme 0, 1-0.2 of the aqueous extract of opium should be added to the above formula. Toxic symptoms following the use of the drug were never observed.

Another simple form for its administration is :

<b>R</b>	Æthyleni brom. aromati.	5.0 grammes
	Spir. vini rect.....	100.0 "
<b>M. Sig.</b>	5, 10 to 15 drops well stirred in ¼ glass of milk two or three times a day.	

Very sensitive persons may take the drug in gelatine capsules, associated with almond oil; each capsule containing three drops of bromide of ethylene and six drops of almond oil. Two to four of these capsules to be taken daily.

Dr. Donath has used the drug in twenty-one cases of epilepsy, and reports fully the history of ten of these cases which were under observation for a long period. It was observed that under the remedy's influence the convulsions occurred more seldom, that they were of shorter duration, and milder. Frequently the disease becomes of a much milder type and the period of immunity from the convulsions increased. In some cases the improvement was so great, that the convulsions only amounted to slight muscular twitchings without loss of consciousness. The general condition of the patients was also greatly improved by the treatment. In many respects the drug's actions are far more favorable than those of bromide of potassium.

### IODOFORM IN BURNS.

Rottenberg, in the *Münchener Med. Wochenschrift*, May 5, 1891, speaks of the great efficacy of iodoform in all kinds of burns, and especially those caused by molten iron. His method of treatment is as follows: Through the punctured blisters he pulls a silk thread soaked in a bichloride solution; he then covers the entire surface of the wound with a thick layer of the following salve:

**R** Iodoform.....10 parts  
Vaseline....."too"

This is then covered with rubber or a protective. The salve should be freshly applied daily.

This treatment not only results in a speedy cure, but also relieves almost like magic the burning pains.

### THE TREATMENT OF PNEUMONIA BY LARGE DOSES OF DIGITALIS.

We have already on one or two occasions called attention to the mode of treatment recommended by Dr. Petresco of combating pneumonia with large doses of digitalis, and in the *Therapeutische Monatshefte* for February, 1891, this author publishes an additional communication on this subject, in which he offers a number of arguments and reports of a number of cases to support his position as to the value of very large doses of digitalis in this disease. The dose which this author recommends is simply enormous in contrast to that which is ordinarily regarded as the safe dose of digitalis, Professor Pretresco stating that he does not hesitate in single doses to give as much as 180 grains of digitalis-leaves in twenty-four hours, although he admits that ordinarily the dose for twenty-four hours does not exceed 25 grains. He prefers the infusion made with 4 parts of digitalis-leaves in 200 of water, and then adding 40 parts of syrup of orange-peel, the dose then being a table-spoonful every half hour. He states that in general this dose is very well borne, and that he has never met a single case of poisoning. Dr. Petresco meets the incredulity which has been expressed as to the tolerance of these large doses, with the explanation that he can only have employed inferior quality of digitalis-leaves, with a denial, and states that he has employed the leaves obtained from all the best pharmacists in Europe, with, as a rule, the same results. He states that he has obtained the best results in genuine fibrous or croupous pneumonia. In infectious pneumonia he has usually combined it with antiseptic methods. He also

states that he has obtained satisfactory results in cases of pneumonia complicated with bronchitis and pleurisy, and he claims in the most positive manner to have cut short undoubted cases of croupous pneumonia, so that within twenty-four to forty-eight hours—the time necessary for the effects of the digitalis to be demonstrated—he has succeeded in obtaining sudden and almost absolute reduction of the temperature to the normal, accompanied with reduction of the pulse, while at the same time this disappearance of fever is accompanied by general improvement in the patient's condition, pain and cough being diminished, the temperature becoming normal, while the healing process rapidly goes on to completion. These large doses, with the exception of but rare cases, are without effect on the digestive canal, although sometimes he has met with vomiting as the result of this method of treatment. The most evident symptom detectable as to the effect of this medication is the marked slowing in the pulse, with increased tension. The author publishes a number of sphygmograms, illustrating the effect of digitalis on the pulse in cases of pneumonia, and concludes his paper with the following deductions:

1. Digitalis has an important antiphlogistic action only in its special therapeutic dose.

2. Its specific therapeutic dose of digitalis amounts to from 75 to 150 grains of digitalis-leaves administered as an infusion in twenty-four hours.

3. This dose may be administered in from two to four days continuously, according to the severity of the case. In some cases from 300 to 375 grains of digitalis-leaves being given in four or five days without symptoms of nausea, or in fact, any toxic effect. Treated with this dose, the temperature in cases of pneumonia falls from 1° to 3° C. after a single dose, and from 5° to 6° C. after three doses, while the pulse is slowed from 40 to 60 beats in the minute after six doses. This reduction in the pulse-frequency and in the temperature lasts from ten to twelve days, by which time the normal condition has been gradually obtained.

4. Simultaneously with this diminution in the rate of circulation and respiration, disappearance of all the local symptoms of pneumonia can be noted.

5. The value of this method of treatment is proved by statistics, the mortality of cases of pneumonia so treated with high doses of digitalis being much less than that observable when any other method is employed.



6. The value and harmlessness of this therapeutic dose of digitalis is established by the author's numerous individual experiments and by the cases reported by his scholars.

7. From studies as to the value of this method of treatment the author concludes that the expectant method of treating pneumonia is not only irrational but even dangerous; that the assumption that there is a definite cycle of progress in pneumonia is not warranted; that pneumonia may be cut short by an energetic rational mode of treatment, especially if the method is inaugurated at the onset of the disease, and that, finally, the claim is supported that the treatment of pneumonia with large doses of digitalis furnishes better results than that obtainable by any other mode of procedure.—*Ther. Gaz.*

#### THE TREATMENT OF RHEUMATIC HYPERTYREXIA.

Dr. Herbert C. Male, in the *Practitioner* says: The occurrence of hyperpyrexia in acute rheumatism, though happily rare, is a complication of grave import, and demands most active and immediate treatment.

Previous to 1870, cases of Cerebral Rheumatism with extreme pyrexia were mostly regarded as hopeless. In this year however Meding, published a case of rheumatic fever, in which a temperature of 108.6° was successfully reduced by means of cold affusion and iced enemata; and in the following year Wilson Fox further drew the attention of the profession to the subject by his treatise on *Hyperpyrexia*, and described very fully two cases of extreme pyrexia (temp. 107.3° and 110°), where the treatment by the external application of cold was carried out with success. Since that time the value of this method of treatment has been universally recognized.

It has been abundantly proved that excessive rises of temperature, in rheumatism at all events, cannot be kept in check by drugs alone. Quinine has been given in large doses, as much as 120 grains in six hours. In the case reported below, the patient was saturated with quinine; he had been taking 12 grs. *per diem* for a fortnight previously, and on the approach of hyperpyrexia large doses were given and continued without any apparent effect on the temperature. Salicylic acid and its salts are powerless, and the complication has often arisen in patients who have been throughout their illness treated by full doses of this drug. Antipyrin and antifebrin are

transient in their effects, and are dangerous to continue from their depressing effect on the heart, which is probably already weakened by the disease. Antifebrin was given to the patient A. H. on November 4; the temperature did not rise during its administration, and it certainly had the effect of causing some moisture to appear on the skin which was previously harsh and dry. Delirium was not relieved. It was not thought advisable, in his weak condition, to continue its use.

Relying therefore solely on the employment of cold in reducing excess of temperature, we must decide at what temperature this treatment must be commenced. Wilson Fox has never seen a case of rheumatic fever recover unbathed after a temperature of 106° has been attained. Merchison has known a case recover after a temperature of 106.5°, but he states that this must be extremely rare.

In other diseases, such as typhoid fever and pneumonia, a temperature of 108° has been reached and recovered from, without special treatment, but Wilson Fox thinks that the "power of sustaining life in acute rheumatism after excessive temperature is less than in other diseases"; therefore we cannot afford to wait so long.

Some ten years ago the Committee of the Clinical Society of London made an exhaustive inquiry into this subject, and in their Report they show the necessity of not allowing the temperature to exceed 105°. In six out of eleven fatal cases (unbathed) the temperature did not reach 106°, and they have shown that the treatment by cold is more successful the earlier it is commenced. Moreover the temperature may rapidly rise when once it begins: in a case mentioned by Fox the temperature ran up from ordinary to 109° in two hours.

There are practically but two methods of applying cold to the surface of the body with the view of reducing temperature; by means of the *bath*, and by the *cold pack*.

When the *bath* is used, it is recommended that the patient be lowered into it in a sheet, at a temperature of 90°—100° F., and that it be cooled down by adding cold water, or preferably pieces of ice, till it is reduced to 60° or 70°.

He should remain in the bath till the thermometer, placed in the rectum, has fallen to 101°—102°, unless any symptom of faintness or shivering require it to be discontinued earlier. In many cases the patient's temperature continues to fall after his removal from the bath. He must be

rubbed dry, and placed in bed lightly covered with blankets; if the temperature fall too low, or the patient is shivering, hot bottles and stimulants are required.

The *cold pack* is best applied in the following way:—The patient remains in his bed; he is stripped of all clothing and a mackintosh is placed under him. Towels are wrung out of iced water and applied to the trunk, head, and limbs. These are changed frequently, and the body sponged over with lumps of ice. An ice-bag should also be applied along the whole length of the spine. The temperature must be carefully watched as before, and the pack discontinued when its reduction has been effected.

The *choice of method* to be employed must depend on the circumstances of the case.

In hospital practice where sufficient assistance and all appliances are at hand, the bath is generally preferred. It is doubtless a more thorough method, and appears to be attended by no greater shock or risk to the patient. On the other hand in private practice it is seldom that the bath can be satisfactorily employed, and for several reasons the pack may be preferred. It can be applied at once, it is less alarming to the friends, it does not necessitate the moving about of the patient, it can be carried out by one intelligent attendant without constant medical supervision, and its effect on the patient can be more readily watched. Moreover it has been proved to be thoroughly successful even in extreme cases of hyperpyrexia. Temperatures above 110° F. have been recovered from after treatment by the cold pack, as well as by the bath.

In some cases one bathing is sufficient to effect reduction of temperature, no further excessive rise taking place. In others it has required to be repeated, and it has been used as often as twenty-six times on the same patient with ultimate success.

The length of time required for reduction varies considerably, and bears no proportion to the severity of the case. In the case reported, the time that the pack required to be used varied from half-an-hour to three hours.

The following facts will give some idea of the proportion of recoveries that may be looked for after this treatment.

Wilson Fox collected a series of twenty-two cases from 1867 to 1871, temperatures ranging between 106° and 111.7°; eighteen were treated by ordinary means without the application of cold, and all were fatal; the remaining four were treated by the cold

bath and three of them were successful, the highest temperature being 110°.

The Committee of the Clinical Society of London collected a series of sixty-seven cases during the ten years ending 1879. In thirty-nine of these the temperature exceeded 106°, and in thirty-four the treatment by cold bathing was adopted, and fourteen recovered, the highest temperature being 109°—110°.

Of the more moderate temperatures among these (viz. between 106° and 107°), eight out of eleven cases recovered, over two-thirds. All the cases that were unbathed died.

In the ten years ending 1890 many cases of recovery have been reported from time to time in the journals, and I have been able to find a record of sixteen cases with thirteen recoveries; temperatures ranging from 106°—110.4°. The pack was used in eight of these with two deaths, and the bath in the remaining eight with one death.

It is not possible of course to form an accurate idea of the proportion of recoveries from the study of published cases alone, as it is probable that many unsuccessful ones have not been published, while the majority of successful cases have been put on record. Still there is ample evidence of frequent recovery after extreme temperatures, which under other conditions must certainly have been fatal.

While however recognizing the success that often follows the employment of cold in rheumatic pyrexia, we must ascertain if there are any dangers attending its use.

Bristowe, records a case where the cold bath on two occasions produced such serious faintness, after five minutes' immersion, that it had to be discontinued.

At Guy's Hospital,<sup>2</sup> during 1874 and 1877, death took place on two occasions during immersion; but in these cases the bath was probably too long delayed, and the heart and tissues had suffered too much from the excessive heat to stand the shock.

In several cases violent purgation has resulted after immersion.

In a case previously reported by the writer, tetaniform convulsions, which occurred after the first application of cold, were so exaggerated on the attempted repetition of the pack, that it was impossible to apply it. The patient eventually died asphyxiated during a convulsive spasm. Another case of a similar kind has also been recorded.

These difficulties, however, appear to be exceptional, and it is well to note that the

various visceral lesions, such as pericarditis and pneumonia, so common in acute rheumatism, are no contra-indications to the use of cold. Indeed, as Wilson Fox asserts, intense pyrexia predisposes to congestion of internal organs, and the physical signs of such have been frequently observed to clear up during treatment by cold.

The following case is recorded, not unfortunately, as an example of a cure after cold packing, but to show the marked effect of this treatment in keeping the temperature within bounds over a prolonged period, its reduction being effected on each of the eight occasions on which it was used. It further shows that, on the discontinuance of the treatment, there followed a rapid rise of temperature, with exaggeration of all the symptoms until the fatal termination. The case also illustrates the variability of the time required to effect a reduction of temperature.

The spinal ice-bag was chiefly of service when used in conjunction with the iced towels. When employed alone, it appeared on the first occasion to delay for several hours a threatening rise, and the second time, when the bag was allowed to remain after the removal of the towels, the temperature continued to fall for three hours, and rose again slightly after it was removed. On another occasion, the afternoon of November 5, the temperature rose rapidly in spite of it.

There was little doubt the patient's life was lengthened for some days by the treatment. It prolonged a period when the efforts of nature might have brought about a change for the better, had other conditions been favorable.

Previous to the onset of hyperpyrexia, the patient's strength was already exhausted. He had been ill for over five weeks, with constant pain and want of sleep. Pericarditis had existed long enough to cause such local organic change as seriously hampered the action of his heart, and this further lessened his chances of recovery.

Such a case impresses upon us the necessity of making a most careful record of temperature in all cases of acute rheumatism, and of recognizing at once the earliest signs of approaching hyperpyrexia.

Should the temperature show an undue rise, we should not waste valuable time by the administration of drugs, but endeavor to check it at once by the prompt application of cold.

The result of such treatment in a favorable case, is most gratifying. The patient

may be dying from excess of temperature one hour, and the next may be in comparative comfort, and with prospects of a speedy recovery. One bathing has frequently turned the scale. The treatment may be applied readily both in private and in hospital practice, and should not be withheld from any patient, in whatever circumstances he may be placed.

## MEDICINE.

### SALICYLATE OF MERCURY AS AN ANTI-SEPTIC.

At a recent meeting of the Surgical Society of Paris, Dr. Vacher, of Orléans, read a paper on the antiseptic qualities of salicylate of mercury, which is quoted in the *Bulletin Médical*. He considers the drug an admirable antiseptic, and superior to Van Swieten's solution because solutions of salicylate of mercury need not contain alcohol. Solutions of any strength are perfectly stable and will keep indefinitely. It is non-irritating and a powerful antiseptic. In the treatment of syphilis Dr. Vacher has found it to be of great service, particularly when given hypodermically. The injections produce no pain and cause no local inflammation. The author has used the drug in solution hypodermically in over one hundred cases of syphilis and with the best results. Salicylate of mercury is always well tolerated.

### NOVEL TREATMENT OF GONORRHOEA.

Dr. Hanicka, in the *Reichs-Medicinal-Anzeiger*, May 15, 1891, speaks highly of the following novel treatment for gonorrhoea: A powder composed of equal parts of tannin, iodoform, and sulphate of thallin is applied to the urethra by means of a catheter-like instrument until the former is entirely full of the remedy. Prompt healing is said to take place in every instance.

### NINETY CASES OF PARETIC DEMENTIA.

Dr. G. R. Trowbridge, in the *Alienist and Neurologist*, writes: The very fact that this disease was practically unrecognized in this country forty years ago, and to-day ranks among the worst forms of insanity, is sufficient reason to make statistics on the subject both of considerable interest and value. In all probability there were cases of paretic dementia before the time of Bayle, and although he is credited, I believe, with first having accurately described the signs



and symptoms of it about the year 1825, it is scarcely probable that the inhabitants of this world were exempt from it though it was not recognized and understood as it is to-day.

History is indirectly contradictory to this, and if we are to believe the facts as recorded there were certainly sufficient causes in the Middle Ages to produce a generous supply of paretic dementia, and I have not the least doubt but that it existed to a considerable extent among the so-called nobility of France, England and other European nations, whose ideas of morality and moderation were somewhat at a discount. The same causes which are producing it to-day were in working order then, though perhaps not to so great an extent; and granting that the mental, moral and physical conditions of two centuries ago were practically the same as those of the nineteenth century, it is fair to conclude that this age is not entirely responsible for this disease.

That paretic dementia is increasing in this country with alarming rapidity there is no room for doubt, as the reports of our institutions for the insane show. It is, however, only another indication of the "fast" age in which we live; and this yearly increase of the disorder is not a thing of which the American citizen should be proud, but on the contrary, it should be looked upon as a veritable curse, as it only proves that those vices and immoralities which are the cornerstone of general paresis, are increasing and causing the moral, physical and mental wreck of our fellow-citizens. No one can realize the truth of this better than the medical officers in our hospitals for the insane. In a large number of cases of paretic dementia admitted to hospitals for the insane, causes for the disease are given which are ridiculous in the extreme; and though either through ignorance or unwillingness on the part of friends, or delicacy on the part of the physician, the real and true cause cannot be ascertained, yet in three cases out of five it would be a comparatively easy matter to guess it, as the real causes of paretic dementia can be sifted down to an extremely small number.

The following statistics of ninety cases were compiled from the registers of this hospital, and though they are more or less defective, they present some interesting points.

Of the 3,518 admissions to this hospital, 90 were cases of paretic dementia; 77 of these being males and 13 females. This is about two and one-half per cent of the entire number admitted.

In the State Hospital for the Insane, at Independence, Iowa, of 3,700 admissions, 40, or a little over one per cent, were cases of paretic dementia.

Of 2,297 male patients at the Pauper Asylum of N. Y. City, 284, or a little over twelve per cent, were paretic.

First among exciting causes is the excessive use of alcohol. This is acknowledged, I believe, by the majority of writers to be a great producer of general paralysis. In close relation to it, both socially and as an exciting cause, is syphilis. It is claimed by some that syphilis is not an exciting cause of paretic dementia, but there are cases of general paralysis which cannot be traced to any other source, and the symptoms of this form are so identical with the regular general paralysis that it is stretching a point to claim another name for the disease. It is a distinction without a difference. This, however, does not mean that syphilis always produces paretic dementia to the exclusion of other insanities.

The excessive indulgence of vicious habits, as a rule, is likely to produce some impairment of the mental faculties, and in the majority of cases of paretic dementia, were the truth known, alcohol and syphilis would occupy the first place as exciting causes.

Here, again, the question reverts to one of social standing. Alcohol and syphilis are luxuries which are placed within the reach of everybody, from the laborer to the millionaire, but we find in my ninety cases, on a close comparison, that as the number in the exciting causes lessens, the cause itself becomes more respectable. I found that intemperance was given as a cause, especially among laborers and miners, and the same was true of syphilis, whereas the occupation, being a little better, the cause appeared as overwork, or was unknown.

Paretic dementia, as a rule, does not attack vigorous and well-balanced minds, unless, perchance, heredity plays a part, but is found among the class whose morals are of such a low grade that regard for themselves or others is completely destroyed, and they give themselves up to immoralities and vices which are the exciting causes of the disease. Thirty-four of the seventy-seven cases were due to either alcoholism, syphilis or heredity, or a combination of two or more, and I venture to say that in the twenty-six cases in which the cause was unknown, these three factors would be in the majority. Heredity plays an important part in the causation of paretic dementia,

though I do not think as important a one as alcohol and syphilis, as it acts more as a predisposing cause.

The disease, as a rule, does not attack either extreme age or youth, but on the contrary seems to select individuals in the prime of life. In summarizing these ninety cases, I find that among the men, the youngest case when attacked was 26 years old, and the oldest 63 years; the average of the 77 cases being 41 years and 8 months.

Among the 13 females, the youngest was 21 years of age, and the oldest 56 years, the average being 41 years and 6 months.

In regard to duration, my cases show that among the males (50 cases) the longest time for the disease to run its course was ten years; the shortest, six months. Average of the fifty cases, two years and seven months; and among the females (8 cases) the longest was six years; the shortest, one year and six months; average, two years and eight months. Average of fifty-eight cases, male and female, two years, eight and one-half months.

I have here only taken those cases in which the disease has completed its course, i. e., resulted in death, as some are still here, and others were, for various reasons, discharged.

I think a fair average of the course of the disease is from two and one-half to three years, though, as we have seen, the course in single cases may be varied to either extreme.

The time spent in the hospital by these patients is as follows—and here, again, I shall only consider those cases resulting in death, omitting those which are still here, and those which have been discharged. Among the fifty male cases, the longest residence in the hospital was seven years, the shortest, eight days; average, one year and nine months. Among the eight female cases, the longest residence was three years and two months, shortest, three months; average one year and six months. Average for the fifty-eight cases, one year and seven and one-half months.

The average duration before admission was, males, one year and one month; females, one year and two months.

The ages at deaths were as follows: Males, oldest, 65 years; youngest, 29 years; average, forty-four years, three months. Females, oldest, 58 years; youngest, 26 years; average, forty-four years and two months.

I shall not draw any conclusions from these cases, as I would only repeat those of other writers, but leave that to my readers.

We must realize that if this disease continues to gain ground, and go on increasing, we will have another powerful factor which will aid in the mental, moral and physical deterioration of the American people as a whole.

There is room for improvement in our mode and manners of life, and the sooner we realize it the better it will be for this and future generations.

#### THE STATUS EPILEPTICUS.

Dr. Robert T. Edes, in the *Virg. Med. Month.*, says: The name "status epilepticus," is, or was, applied to a continuous succession of epileptic fits, coming so rapidly that one does not end before another begins; that is, if we count as a fit not only the period marked by active convulsive movements, but the stage of unconsciousness succeeding it.

This is the usual condition, but it is probable that the same, or a similar, pathological state prevails, and may very properly bear the same name where the convulsions are not all very well marked, but are indicated, or at least some of them are so, simply by muscular twitchings not developing into general convulsions.

Rise of temperature, pulse and respiration are characteristic symptoms; and some others noted in my case, as the extremely dirty tongue, and the rapid supervention of sloughing of the nates, have been commented on before.

In the more typical cases, the status epilepticus is divided into two stages—one marked by the severity of the convulsions, and a second comatose, delirious, or collapsing, which has been termed, though improperly, the meningitic stage.

In looking over the recommendations of authors for treatment, one finds that they agree chiefly on one point, the uselessness of a large number of drugs.

Nitrite of amyl, however, seems to have been of considerable value. It was tried, but not very successfully, in our case first reported. In the other, it was of decided advantage. Amylene hydrate has also been highly spoken of.

In one case he was confident that ether had a decided effect in postponing the attacks, and chloral hydrate, in not excessive doses, by the rectum, was even more efficacious. How far chloral, if used early and freely, might have been efficient, not merely in checking the convulsive movements, but in preserving life, is not so easy to say. It

certainly seems to me that, either alone or combined with bromide, it gives the best chance of attaining this object.

It is not, however, so easy to be certain of this, for the reason that in some cases, and some fatal cases, the severe muscular contractions are not the most prominent features, but the coma and fever, with a few well-marked convulsions, and a more or less constant, but not violent muscular twitching, seems to constitute the disease.

In the comatose stage, or that of collapse, chloral would certainly not seem indicated. He was surprised not to find it even mentioned in either of two monographs\* founded on an apparently thorough study of the subject.

A phenomenon, which is sufficiently often seen to have been considered by some writers essential, or even diagnostic, is a moderate and usually evanescent hemiplegia. This has been wrongly attributed to some gross permanent lesion in the brain, which by no means invariably exists.

In one case, nothing of the kind could be observed, although repeatedly and carefully looked for. The only possible indication of any unilateral affection was the turning of the eyes and head to the right for a few seconds at the beginning of a fit.

In another case, there were differences of sensation and slightly of motion in the two sides, but the only gross lesion noted was in the median line.

#### A CASE OF PSEUDO-CHOREA.

When first seen at the out-patient department the most conspicuous features about the case were clonic movements of some of the muscles of his trunk, which jerked the latter forcibly to the right side, the diaphragm being affected at the same time, so that a grunting inspiratory sound was produced which often interrupted his speech in a quite characteristic manner. His gait was hemiplegic and the muscular strength was found to be distinctly subnormal on the entire right side, the movements were confined to the trunk and followed each other in quick succession. The motions of the limbs were found only to be communicated. The man was totally unable to walk alone.

As regards his family history, we were told that the patient's father had died with an acute brain-trouble, the exact nature of which, however, could not be ascertained. The patient had been well and strong. No

excesses in *Baccho aut Venere*. No syphilis. In 1888 he entered the army. In 1889 he was in Washington Territory with his regiment and much exposed to wet and cold. During the next summer, following a good deal of exposure, he was attacked with severe pain in his back, which shot down into his legs, especially the right one to the toes. The joints were neither swollen nor red, but the attack was of considerable severity, so that, as he states, he was unable to walk for between two to three months. While still at the hospital, he had an attack of the same nature as the present one, which persisted for four months and gradually disappeared. With the exception of a very slight return in the spring of 1890, he remained perfectly well until 15 days before he was first seen. While driving a wagon the axle broke and he was thrown out. He was not hurt, but two hours later the jerking movement referred to above suddenly appeared.

Two days after presenting himself at the dispensary he was admitted to the hospital, the condition was then slightly better. A more careful examination was made. The *latissimus dorsi*, the *rhomb.*, the *serrat.*, were found to be especially affected. The *pectoralis* less so. Of the abdominal muscles the *rectus*. The diaphragm as stated above. The weakness of the right side still well marked. Some tenderness over the *erect. spinæ*.

About the movements the note, which was dictated by Dr. Lafleur, says: "the movements are of great rapidity and have almost a rhythmic character jerking his body to the right in a manner which reminds one somewhat of the canine chorea."

The viscera showed no changes.

He was found to have dulling to sensation of pain (not of touch or of heat) in the whole right side with the exception of the face. There is diminution in the reflexes on that side. The perimetric fields of both eyes were equal and normal. The special senses are in no way affected. Electrically there was no change found.

The patient was placed in a room by himself and no medication save a placebo was given.

The improvement was rapid and remarkable. He slept comfortably, the jerks diminished in frequency and four days later only occasional movements were observed, and still three days later they had almost completely ceased. Now the only features remaining are the sensory changes and the changes in the reflexes. The resemblances

\* Hertz.—*Status Epilepticus*. *Inaug. Dissert.*, Bonn, 1877. Lorenz, *op. cit.*



to Sydenham's chorea exist of course only in a rough way. The points which are unlike the true chorea, are: (1) the almost rhythmical character of the movement; (2) the electric-like character of them; (3) the fact that they were confined to the trunk; (4) the sensory changes; (5) the fact that in a quite short time the movements reach the greatest severity.

The case, therefore, must be classed under the head of Pseudo-chorea, which belongs under the large heading of Hysteria.—Dr. Hoch in the *Johns Hopkins Hosp. Bull.*

## SURGERY.

### MICROCIDIN—A NEW ANTISEPTIC.

At the meeting of the French Academy of Medicine, held in Paris, April 28, and reported in the *Bulletin Médicale*, April 29, 1891, Dr. Polaillon read a paper on the subject of microcidin, a new antiseptic which has recently been discovered by Dr. Berlioz.

A quantity of *B* naphthol is heated to the melting point, and the half of this quantity (by weight) of caustic soda is added and the mixture allowed to cool. The result will be a white powder composed largely of naphthol and soda, but besides this composites of naphthol and phenol, which give the substance peculiar properties which seem to justify the name of microcidin, which Berlioz has given it.

The substance is soluble in three times its weight of water. Concentrated solutions are of a brown color, while the weak solutions are almost colorless. It is but very slightly toxic. Its antiseptic properties are weaker than those of bichloride of mercury and naphthol, but it is ten times as strongly antiseptic as carbolic acid in solutions of similar strength. The toxicity of microcidin is less than that of naphthol, and, of course, infinitely less than that of bichloride of mercury. The substance is almost entirely eliminated through the urine.

Regarding the clinical value of the preparation, Polaillon has used a 3 per cent. solution of microcidin with excellent results in leg ulcers, various suppurations and suppurating wounds. The solution is non-irritating, promotes healing, and keeps the wound clean.

### SURGICAL AND CLINATIC TREATMENT OF PHTHISIS.

An interesting monograph on the above subject has been recently published in Ger-

man, by Dr. C. Spengler, of Davos (Switzerland).

The author claims that neither cavities, empyema or pyo-pneumo-thorax can heal unless the necessary mechanical conditions are brought about. Arguing from this point Spengler advocates the establishment of an open pneumo-thorax, by a free resection of ribs. In advocating this procedure he places himself on the same stand as Schede and Immermann. In young subjects the method promises better results than in older patients. The principle consists in the hypothesis that the atmospheric pressure on the lung would cause a shrinking of the thorax. Of course, there is always more or less displacement of the organs of the chest, especially the heart, but not enough to cause any untoward effect. This treatment should be supplemented by a careful dietary, hygienic and climatic treatment—high altitudes being preferable. Finally, Spengler cites many cases which show the efficacy of the treatment, although in many cases sufficient time had not elapsed to warrant a more than improved condition.—*Centralblatt für Chirurgie*, April 25, 1891.

### SURGICAL TREATMENT OF APPENDICITIS.

Dr. Randolph Winslow, in approaching this subject from a surgical standpoint, states that there was great difficulty experienced from the confusion in the nomenclature applied to the inflammatory troubles in the right iliac fossa, and that this confusion in nomenclature meant an equal obscurity in our ideas of the pathology of these affections.

The terms typhlitis, perityphlitis, and paratyphlitis, are used more or less indiscriminately for painful inflammatory affections of the right flank, which may be widely different in character.

*Typhlitis* is an inflammation of the cæcum, which may be limited to its mucous coats, or may penetrate more deeply, until the peritoneal coat is reached, when the resulting peritonitis, with its accompanying exudation, is called *perityphlitis*; and if pus forms, a *perityphlitic abscess* is said to be present.

It was supposed until quite recently that the cæcum was only partially covered by peritoneum, leaving a large part of its walls with no peritoneal coat, and in immediate relation with the post-cæcal connective tissue. This is an error, the cæcum has a distinct mesentery in the vast majority of cases, and floats quite freely within the

peritoneal cavity. And when an abscess forms, it is almost invariably found to have its primary seat within the peritoneal sac—the diffusion of the pus being prevented by adherent coils of intestines. Sometimes, as a secondary result, the peritoneum is destroyed and the pus escapes into the post-peritoneal connective tissues. It would be much better to use the terms *cæcitis* and *appendicitis* to describe inflammations of the cæcum and vermiform appendix, and to discard such expressions as *typhlitis*, *perityphlitis*, and *paratyphlitis*, as being obscure and obsolete. *Cæcitis* or *typhlitis* is a disease amenable to medical measures, and but seldom calling for surgical treatment, whilst *para-* and *peri-typhlitis*, meaning thereby an inflammation of the post-cæcal connective tissue, but seldom occurs.

As the various inflammatory conditions within the female pelvis are usually found to depend upon disease of the Fallopian tubes, so the inflammations found in the right iliac fossa usually have their origin in diseased conditions of the vermiform process. It is very important, therefore, that we should have correct ideas about this very troublesome and apparently useless bit of anatomy.

The *vermiform appendix* varies in size, length, and position; sometimes it has quite a distinct mesentery, but generally it is quite free, and may be found occupying almost any relation to the cæcum. Its tip may be found in the pelvis or turned upwards and attached to the abdominal wall or some of the viscera, or the whole process may be found behind the cæcum, or in fact occupying almost any relation to this gut.

It is probable that the appendix is frequently diseased without producing very decided or distinct symptoms, and that recoveries occur both with and without treatment.

When, however, *acute appendicitis* sets in, the symptoms are generally quite characteristic; but it is not every case of acute appendicitis that demands operative treatment. When the symptoms are not very severe, the pain not intense, and the fever not high, and especially if no tumor is to be felt, reliance should be placed upon medical treatment; a careful watch should, nevertheless, be kept for evidences of the development of more threatening symptoms. Even where there is a swelling found in the right iliac fossa, it does not necessarily demand operation. He has seen a number of cases recover after a decided exudation had occurred, without operation or any appreciable discharge of pus.

It has been recommended, and in many cases carried out, to aspirate the suspected region. Whilst this method has yielded good results, he is unable to approve its employment, as it is excessively hard to properly disinfect an aspirating needle, and a serious accumulation may become converted into a purulent one, besides the risk of penetrating the intestines or some blood vessel. When the diagnosis must depend upon the detection of fluid within a circumscribed space, it will be less dangerous to make an incision down to the seat of disease, than to aspirate.

When a decided lump is found in the right iliac fossa, which is hard, tender, and painful, and the fever keeps up, and especially if this lump increases in size, an incision should be made both for purposes of exploration and treatment. This incision should not be too long delayed, as the pus may break through the adhesions which circumscribe it, and set up a general suppurative peritonitis. It is not safe to wait until the sign of fluctuation can be detected, as this may never occur, or may occur only at a late period. The earlier the operation is performed the greater the probabilities of a successful termination. It may be stated that operations, when indicated at all, ought to be made as early as the fifth or even the third day.

When the symptoms of perforation come on, as sudden and intense pain with collapse, operation ought to be performed as soon as there is sufficient re-action to justify it; otherwise a generalized peritonitis will probably set in and terminate fatally. There are a few cases of perforative appendicitis, which present such obscure symptoms, that the nature of the disease is not suspected until a fulminant peritonitis is set up, with pus-bathed intestines and viscera, when it is too late to save the patient by laparotomy.

Dr. Winalow thinks we should emphasize the fact that the exudation, or pus, in a case of suppurative appendicitis, is found within the peritoneal cavity, and not in the post-peritoneal connective tissues; hence, the great danger that the adherent coils of intestines may become separated, and fatal general peritonitis occur.

Having determined to operate, the seat of incision is usually over the swelling, as thereby the most ready access to the abscess cavity is gained. The tissues are divided by a straight or curved incision in the right flank until the transversalis fascia is reached, when an aspirating

needle or hypodermic needle may be thrust in various directions into the swelling, if there is any doubt about the presence of pus, or the tissues may be cautiously divided until the peritoneal cavity is opened, when the exudation of pus or serum will be reached. If the appendix is perforated, or even if it is manifestly diseased, it should be ligated close to the cæcum and cut off. Sometimes the appendix will not be found—it has sloughed off and disappeared. It is usually better not to irrigate the abscess cavity, as there is danger that by so doing pus may be forced into the general peritoneal cavity. Free drainage should be secured, and as far as practicable, antiseptic treatment adopted; but this will be difficult, as the discharge is of an especially septic character.

As surgeons, we are also called upon to open the abdomen in those cases where the pus has set up a general peritonitis, though with but slight hope of success. Here the incision should be placed in the linea alba, with perhaps incision for drainage for one or more other points. The peritoneal cavity should be thoroughly cleansed, the intestines sponged off or washed, and free, and if possible, continuous irrigation with warm water, or a weak antiseptic solution kept up—several drainage tubes being placed in favorable situations. One or two cases have been recorded of recovery after continuous irrigation for several days.

A certain quite large number of cases of appendicitis recur after having apparently healed, and not only give rise to considerable local reaction, but even to danger.

Treves, of London, and Senn, of Milwaukee, recommend the removal of a diseased appendix during the intervals of quietude from acute outbreak, and report several successful operations in such cases. Dr. Winslow is strongly inclined to the opinion that this is correct surgical doctrine, notwithstanding the protest of Dr. Dennis, of New York, against it; and he will certainly carry it out in practice in appropriate cases. Dr. Winslow referred to a patient who has had two attacks of painful febrile affections on the right side of the abdomen, the first of which was recovered from under medical treatment, and the last, after incision, who is determined to have the more radical operation performed if he has another recurrence.

In conclusion Dr. Winslow submits the following propositions:

1st. Inflammatory affections in the right iliac fossa are atmost invariably due to dis-

eased conditions of the appendix vermiformis.

2nd. When an abscess forms in the course of such affections, the pus is found, primarily, within the peritoneal cavity, and not in the post-cæcal connective tissue.

3rd. Many mild, and some severe attacks of appendicitis are recovered from without operation.

4th. When there is severe localized pain, tenderness, and a tumor present in the right iliac region, with the constitutional suppurative inflammation, an early operation is demanded to evacuate the pus. This should be done as early as the third day when possible.

5th. Delay is more dangerous than operation, as the adhesions circumscribing the pus may give way, and a rapidly fatal peritonitis may be set up.—*Virg. Med. Month.*

## GYNÆCOLOGY.

### INCISION VERSUS RAPID DILATATION FOR STENOSIS OF THE CERVICAL CANAL.

Dr. James H. Reilly in a paper before the *Vermont Medical Society* said: I feel that I owe the society an apology in claiming that better results can be obtained in the treatment of constriction of the cervical canal for dysmenorrhœa and sterility than by the more modern procedure, rapid dilatation, as advocated by Goodell and other eminent gynæcologists; but after an experience in the treatment of forty cases, my statistics force me to take the stand that I have taken.

When cases of this kind first came under my direct observation for treatment, I resorted to the operation by means of rapid dilatation as a means to produce a radical cure. I assisted at the operation a great many times during my service as hospital interne, and whilst I looked upon the operation as a barbarous procedure, it evidently accomplished the dilatation to such a marked degree that I reconciled myself with the idea that the end justified the means. That the canal could contract again to the same degree as before operation appeared at that time to me an impossibility, but it was not my privilege to watch the progress and termination of these cases after leaving the hospital, and, not hearing of any unsatisfactory results, I concluded that the operation must have been very gratifying to the operator as well as to the patient. After entering practice, when cases of this nature



presented themselves to me, the first operation that suggested itself was that of rapid dilatation; and after meeting with cases where, after dilatation to the maximum extent (suggested by enthusiastic advocates of the operation), and carrying out the after-treatment in the manner advocated by them, the contraction was as marked as before the operation, if not to a greater extent, I have concluded that the operation does not overcome, to a permanent degree, the contraction of the cervical canal.

The causes for which we are called upon to do this operation generally are dysmenorrhoea and sterility. When I say dysmenorrhoea and sterility, I do not mean to say that all cases of painful menstruation are due to a constriction of the cervical canal, nor that all cases of sterility are due to this condition. I have only reference to those cases where every other reason is excluded and a stenosed condition of the cervical canal exists. When called upon to treat a case of sterility, I think we are justified in operating if this condition is found to be present, although history of dysmenorrhoea is not associated with the case, a condition not at all uncommon; in fact, the only case of sterility which I have successfully treated by rapid dilatation is that of a woman who presented herself to me for treatment with the following history: She had been married eight years, was twenty-one years of age when married, and had never had any serious sickness. She was very anxious to have children, and stated that if the fact that she had none was due to any condition that could be corrected she wanted to have it done. She menstruated regularly, and never had severe pains immediately before or during this period. There was no ulceration around the external os. On passing the sound it met with considerable resistance at the internal os, and was forcibly passed through. The uterus was found to be in its normal position. The only condition about her that I found to which her sterility could be attributed was this apparent constriction at the internal os. I dilated this rapidly under ether, passed a sound at short intervals for a month, after which I did not see her for four or five months, when I was called to see her for some of the disagreeable symptoms of pregnancy, and in a year from time of operation I delivered her of a twelve-pound boy.

Of the forty cases that I have operated upon, ten were for sterility and thirty for dysmenorrhoea. On the first ten cases that came under my observation for dysmenor-

rhea I operated by rapid dilatation, and of these but four were relieved permanently. The condition of six others, after periods varying from three months to a year, was as bad, and in two cases worse, than before operation. They underwent a secondary operation by incision, and after a period of from one to two years I have yet to hear of an unfavorable result. Of the remaining thirty cases operated on by incision, permanent relief followed in every instance. Within the last six months I have operated on three cases which I have not included in my statistics, as I do not regard a case permanently relieved until they pass a period of one year without a recurrence of the trouble. Of the ten cases operated upon for sterility, six underwent the rapid dilatation operation. This operation proved effectual in but one case, and that as reported. After one year's time the contraction was as marked as before the operation. They underwent a secondary operation by incision. Two of them have borne children, and one other is well advanced in pregnancy, and in one the constriction is as marked as before the operation. The other patient passed from under my observation about six months after the operation. She was not pregnant at the time. On four patients I have done the operation by incision during the past year; two are now pregnant—one two months after the operation, and the other four months. On two I have operated within the past three months, and they are still under my observation.

The constriction in every case that came under my observation has been at the internal os. In not a single case have I met with any resistance with the ordinary sound until I came to the internal os, and in every instance the constriction has been so marked that an ordinary probe could not be passed unless considerable force was used. What we accomplish by dilatation is a paralyzation of the sphincter muscle surrounding the internal os, but it is only a temporary paralysis, and will gradually resume its functions again in the same manner as the sphincter ani, and after forcible dilatation for diseases peculiar to the rectum. The great tendency for this muscle to contract again after dilatation is not at all surprising. Very true, the muscular fibres that are ruptured by the dilatation lose their power of contractility, but it is almost an impossibility to rupture them all with the instruments devised for rapid dilatation, and I doubt whether we will rupture any of the fibres if only carried to the extent

advocated by some authors. When we reflect and consider how soon after labor, where the muscle surrounding the internal os is put upon a stretch to an extent of six times as great as can be accomplished by any of the dilatation instruments now in use, and how soon after it resumes its power of contractility, it is inconsistent to expect to deprive the same muscle of its function under the force of the instruments devised for that purpose. The operation by incision is not attended with any more danger than by rapid dilatation. A number of instruments, called hysterotomes, or metrotomes, have been devised to do the cutting. The objection to these instruments is that they do not incise deep enough. In my hands the long, blunt-pointed bistoury has accomplished the desired result without any trouble.

Pelvic peritonitis or cellulitis is a contra-indication for the operation; in fact, it is essential that any inflammatory trouble peculiar to the pelvis should not exist to have the operation successful. If the operation is done and any inflammatory trouble exists, the operation is certain not to be a success, but the inflammatory condition aggravated. This does not include endometritis; but, on the contrary, when this disease exists, which it does very often in consequence of a stenosed condition of the internal os, the cure of it is facilitated by the opening of the os.

The operation should be done as soon after the menstrual period as possible. This will give the tissues sufficient time before the next period to become completely healed. If the tissues are in an inflamed condition at the subsequent period, contraction is very sure to follow; for this reason a patient should not be operated upon close to a menstrual period.

A mild cathartic is given the night before the operation. If this does not prove effectual by time of the operation, the bowels are unloaded by means of a rectal enemata. A vaginal douche is given the morning of the operation; this leaves the parts in a proper condition for the operation. The various steps in the operation are as follows:

The patient is anesthetized and placed on a table, and a bivalve speculum introduced, or a Sims, whichever is preferred by the operator. The cervix is grasped by the forceps tenaculum and held in a fixed position. A dilator is passed to open the os up to a degree large enough for the bistoury to enter. After passing the bistoury, the next step is to make the incisions. I resort to

the crucial incision, one anterior and one posterior and two lateral incisions. A blunt-pointed, double-edged bistoury has been devised to simplify the operation by avoiding turning the instrument. I use the single-edged one, and do not experience any difficulty in turning it from one wall to the other. The depth of the incision is governed by the experience of the operator. The danger of a deep incision lies in the severing of the circular artery. As near as I can determine, the depth of the incision I usually make is about three-eighths of an inch. The hæmorrhage is controlled by compression with absorbent cotton passed into the canal on an applicator. Occasionally I have found it necessary to resort to applications of the persulphate of iron to control the bleeding. A douche of hot water is again given, a stem pessary introduced and held in place by tampons saturated with a solution of glycerine and carbolic acid (ten grains to the ounce), a hypodermic given, and cold applications are kept over abdomen for about four days. A vaginal douche is given once a day for about ten days. If symptoms of pelvic inflammation develop, the pessary is taken out and a sound or dilator passed every few days, and hot applications are to be made instead of cold. It is the exception for inflammatory symptoms to develop. The patients generally make uninterrupted recovery, and are able to be around the tenth day. The pessary can generally be left in for three weeks before removing. If the period is due before that, it will be essentially necessary to remove it at the expected time. The patients are instructed how to place tampons themselves. If the operation is for dysmenorrhœa, sounds should be introduced a few days before the expected period; if for sterility, I generally wait until after the period before their introduction. If the patients are not carefully observed and dilatation kept up for a year after operation, it is certain not to prove effectual.

#### DRAINAGE OF THE ABDOMINAL CAVITY AFTER LAPARATOMY.

While the majority of German gynecologists practice the immediate and complete closure of the abdominal wound after laparotomies, a number of the foremost operators, both in England and America, speak in favor of abdominal drainage. Dr. M. Sânger, has recently performed fourteen laparotomies in which he has used drainage, and he claims to be forced to the conclusion that the course of such cases is much safer and less

critical than when drainage is omitted. Finally, the danger of poisoning by blood ferments is entirely obviated. There are three forms of abdominal drainage: first, the tubular drainage, with straight or bent glass tubes; second, the intra-abdominal tampon, with absorbent gauze; third, a combination of the glass tubes and absorbent gauze.

In eleven of the cases reported by Snger, in the *Deutsche Med. Wochenschrift*, the last named method was employed. A most carefully cleaned and sterilized bent glass drainage-tube was used, its sides being perforated with a number of small holes. After closure of the abdominal wound, several strips of absorbent gauze were placed in the tube by means of a similarly bent copper sound. Over all this an antiseptic and if possible an hermetically closed bandage dressing was applied. The dressings were renewed in twenty-four hours.

### OBSTETRICS.

#### STRYCHNIA AND THE HOT DOUCHE IN THE PROPHYLAXIS OF PROTRACTED LABOR.

The following observations on the use of small doses of strychnine, given for a period prior to labor, may prove interesting. From a therapeutic point of view they are certainly useful.

I have given strychnine in one hundred cases, and the effects, as far as the children were concerned, were very gratifying. Out of the entire hundred births there were only two children still-born. One of these had evidently been dead in utero for some considerable time, and was quite macerated and softened. The other was lost by the twisting about the neck of a short cord.

With regard to the mothers, the strychnine acted as a bitter tonic and improved the appetite; its use stimulated the movements of the bowels, and to some extent prevented the constipation that is so general in pregnancy. At the time of labor not one of the patients treated with the strychnine had convulsions, so that it cannot be regarded as unsafe for this reason. Its action on the uterus was satisfactory, the contractions being regular and normal, and entirely free from any tetanic condition, as is sometimes seen after the administration of ergot during labor.

The state of uterine tone was improved by the strychnine. The contractions of the uterus were longer maintained, more regular

and satisfactory, than in the case of those to whom the strychnine had not been given. The after-contraction of the uterus was better, and after-pains were greatly lessened, as the firm condition of the uterus prevented the formation of clots and the occurrence of jerky, twitching, clonic uterine action that is often so distressing to the patient. The amount of hmorrhage was reduced. There is an impression in the minds of many that the bleeding after labor is arrested by the formation of clots in the uterine sinuses. Such, however, is not the case. The uterine vessels are surrounded by the interlacing muscular fibres of the uterus. It is the steady, firm contraction of this muscular tissue that must be regarded as the true hmodynamic, and not dead, inert clots.

Another feature well noted in the cases where strychnine had been given was that the recovery was quick and better than the average. There are several reasons for this. The shorter period of labor must have had some influence. Then the fact that there was less blood loss is important. The firm tone of the uterus, effecting speedy and good involution and controlling the after-pains, also had its share in aiding the recovery. Good, firm uterine tone lessens the risk of septic absorption, and by so much favors the patient's recovery.

Concerning the duration of labor, the following figures may assist in conveying an idea of the general usefulness of the drug. It should be remarked the treatment was adopted in cases where previous labors had been protracted owing to uterine inertia, irregular and crampy pains. Primiparæ were excluded in all cases. The one hundred cases treated with the strychnine gave an average of nine hours, whereas the average of the previous protracted labors, in the same one hundred patients, was seventeen hours. Here we have an average gain of eight hours on previous tardy deliveries, the second stage being much shorter.

The dose of the drug varied with the susceptibility of the patient. One could not tolerate more than the sixtieth of a grain. A number had reached their maximum dosage when taking one-fortieth three times daily. About one-half of the entire number bore the thirtieth of a grain well. The largest dose given in any case was the sixteenth of a grain three times a day. This amount was administered to one patient, who, during two prior labors, had almost complete uterine inertia.

It is quite possible that other tonics, such



as iron and quinine, would exert a beneficial influence where there was anemia and debility.

As a means of prophylaxis against a protracted first stage caused by a rigid and undilatable os, I strongly recommend a hot douche. All are familiar with the excellent effects of this measure in the first stage of a lingering labor, but it has not been used as prophylactic against a tedious first stage due to rigidity of the maternal tissues. The plan I have adopted is to take a new tin pail holding about two gallons, and have a small spout put on the side near the bottom. To this are attached a few feet of rubber tubing carrying a good vaginal nozzle. The pail is filled with water at 105° to 110° F. The patient sits over a receiving vessel; the nozzle is then introduced and the flow started. In this way the cervix and vagina are thoroughly douched. One caution is needed—that the hydrostatic pressure be not too great. All that is requisite is just enough to make the water flow.

It may be said that the use of the hot water will induce labor before the full term has been reached. Such, however, has not been the case in my experience. But grant that it should come on a few days sooner than it would if the douches had not been used, what harm could there possibly arise from such a circumstance? If there is not too great force in the water flow, so as to effect some separation of the membranes, there need be no fear on this score.

The douche ought to be used twice a day for a short time before labor, a week or ten days being sufficient to soften and relax a very rigid os. The local application of the hot water stimulates the blood supply of the pelvic viscera, increases the activity of the glands, and allays much of the sensitiveness of the cervix. When labor sets in the os yields sooner, is less tense and less liable to tear. The first stage is in this way very materially shortened. The abundant secretion of mucus aids the second stage. The second stage is also shortened by the relaxing action of the douches on the perineum; it, like the os, is found to yield to the pressure of the advancing head, and time and suffering are saved.

These douches may be ordered with advantage in all cases where rigidity and slow dilatation is probable, as in primiparæ, or where previous tedious labors have been known to be due to tense and rigid structures. Many patients of this latter class have gone through subsequent accouchements with comparative ease and rapidity after the use of

the hot water for ten days prior to term.—*Dr. John Ferguson, in Amer. Jour. Obstetrics.*

#### RETAINED PLACENTA IN MISCARRIAGE— HOW SHALL WE TREAT SUCH CASES?

Dr. A. J. Swaney in the *Southern Practitioner* writes:

The reasons given for active interference are the frequency of these dangers in prolonged delivery of the placenta. The almost constant possibility of manual extraction which at once assures the woman's safety from the dangers of hæmorrhage and septic poisoning, Simpson, Munde and Grandin are perhaps the most active partisans for interference. Simpson directs if the cervix is dilated, or patent to act at once, if it is not dilated, he dilates at once. The woman is first anesthetized, the uterus depressed as much as possible by the external hand and with the index finger of the other hand, he removes the placenta and membranes. If he cannot sufficiently depress the uterus with the hand, he does not hesitate to forcibly drag it down by a double tenaculum fixed in the cervix. Mundé and Dr. E. H. Grandin, of New York, go still further, and curette the cavity of the uterus with special instruments made for the loosening of adherent placenta and its removal from the uterus. These curettes have no cutting edge and are applicable to cases where there is a large mass to remove, and where in consequence nearly always the cervical canal is open and will admit them. When dealing with shreds and the os is less patent, the dull curette of Thomas answers every purpose. They place the woman in the left lateral position and the removal is through a Sim's speculum. Dr. Grandin then directs, after the removal of the placenta, that the cavity of the uterus should be carefully dried by cotton applicator and tamponed by a slide applicator, the cotton on which has been saturated with the compound tinct. of iodine. The compound tinct. of iodine is used as a gentle styptic and disinfectant, or if there is much fetor iodoform is preferable. The authorities who counsel waiting for serious complications before interfering are just as many. We mention Rambotham, Davis, Burns, Fleetwood Churchill, Grailey Hewitt, Charpentier, and many others. Charpentier, in his *Cyclopædia of Obstetrics and Gynecology*, says:

"If the woman miscarries in two stages, if the fœtus has been expelled and the placenta remains, what is to be done? Usually nothing: nature can do the work.

The placenta may remain days before being expelled; whilst there are no complications, wait at least till the placenta is engaged in the cervix and detached from the uterus, and then extract. If the placenta is not engaged and the cervix is closed, wait, and in case of hæmorrhage tampon, give ergot, never the ergot alone. If the placenta is still adherent, and is in part engaged in the cervix, give ergot, for the cervix cannot contract, since its canal is filled by the placenta. If the placenta is at the fundus and adherent, wait in case there are no complications, but interfere in case of accident. If it be hæmorrhage, the tampon and ergot. If it be putrefaction of the placenta, recognize this and extract at once; we must not hesitate, but we must immediately extract the placenta or secundines, and this, it is understood, is all the more difficult, the more completely the cervix has closed. If the cervix is permeable to the finger or instruments, the operation is easy. If closed, then we must dilate at once with sponge, branched steel dilators, or with Barnes' bags. Dilatation once accomplished, we must proceed to extraction, and this must be done by the finger or instruments, according to the case. He directs after the cervix has been dilated, and the woman on her back, to depress the uterus with the left hand as much as possible, and with the index finger of the right hand introduced into the cavity of the uterus, or as deep as possible, the adherent remnants are detached and brought away. If this does not suffice he resorts to instruments."

Septicæmia being one of the dangers from putrefaction of the retained placenta, how are we to recognize this. The first symptom is fetor of the lochial discharge. The discharge further loses its normal character and diminishes in quantity, becoming in color black or brown. It is no longer bloody or sero-sanguinolent, but is composed of reddish-black detritus, the debris of the retained mass, involution ceases and the uterus becomes sensitive to pressure. At times tympanitis supervenes with or without diarrhoea. The woman has chills. Sometimes the chills are violent and single, at other times many, separated by intervals of one or two days. There is fever, the temperature rising to 104°, 105° F. The pulse ranges to 120 or more. The temperature shows a marked remission, but the pulse remains high, and thus it may be day after day until the woman dies, or the fever may be continuous. The general condition alters for the worse. The eyes are sunken,

anorexia and vomiting exist, the woman grows weaker, and if we cannot suppress these symptoms, dies of septic poisoning.

Has the physician any business to allow a woman with retained placenta to enter such a state as this? Is he doing his duty to sit calmly waiting for the onset of sepsis? He knows what he ought to do in case of sepsis, but action then, no matter how prompt, may fail, and the woman die of septicæmia. Then, as we cannot tell in any given case of retained placenta or secundines whether or not sepsis may develop, which is the wise course to pursue? To sit calmly waiting for the approach of these dangers, as advised by Charpentier, Ramsbotham, and others; or to act promptly, as advised by Mundé, Grandin, and others? I believe with Munde and Grandin, that active interference in the removal of the retained placenta is safe, easy, and forthwith guarantees the woman against sepsis. Active intervention does not mean unnecessary intervention. Nature is ever to be given a chance, but when we see her efforts are futile, certainly it is but rational to assist her, and this should be done as directed by Mundé and Grandin, by placing the woman in the left lateral position, and with a dull wire curette remove the placenta or any part of the secundines that may remain through a Sims speculum. This is far better and easier than the method advised by Simpson, of dragging or pressing down the uterus and introducing the finger into the uterine cavity. The uterine cavity should then be washed out with hot water slightly carbolized through a Jamson uterine douche, and repeated every six or eight hours until all fetor disappears from the lochial discharge.

I am painfully aware of the fact that a very large majority of physicians follow and practice the expectant or do-nothing plan, being satisfied with giving ergot and vaginal injections. It would doubtless be a surprise to many if we could ascertain the number of valuable lives that have been lost and the amount of suffering entailed upon women from the neglect of removing the retained placenta. Who of us with much experience has not seen such cases?

Shall we give ergot in retained placenta? This is another practice which should be relegated to the past. Engleman says never give ergot until the uterine cavity is cleared. The contractility evoked by ergot is notably different from that which is peculiar to the uterus; it is a species of tetanic contraction which, when it affects the cervix, not only

does not cause dilatation, but produces rigidity. Ergot may then act directly opposite to the end desired, and by interfering with dilatation of the cervix shut up the uterine cavity. Hæmorrhage after miscarriage, even when we believe the placenta and membranes have been removed, invariably means retention of a part of the placenta or secundines. Profuse hæmorrhage may occur for weeks from this cause. In such cases we should boldly explore the uterine cavity and remove any offending matter that may be present.

In the first twelve weeks of pregnancy, the dangers from hæmorrhage and septicæmia are not so great, and the expectant plan is more justifiable. After the third month it is criminal negligence to wait and subject a woman to the dangers arising from retained placenta, when she can be relieved by an operation, which, if properly done, can do no harm and spare her the risk of hæmorrhage and septic poisoning.

Again, with Mundé and Grandin, I repeat. The early removal of the secundines is easy, safe, and forthwith guarantees the woman against the dangers of hæmorrhage and sepsis.

It has been said that necessity is the mother of invention. I now show you an instrument improvised and made fifteen years ago by Dr. Thomas M. Woodson, of Gallatin, Tenn. As you see, it is simply a wire doubled and twisted together, leaving an open space at the end, as the wire is brought back. This opening is about one-half to three-quarters of an inch wide and two inches long, and is then again bent to resemble a spoon. This is as good a curette as Tieman can make, and was devised and used by Dr. Woodson to extract a retained placenta in a miscarriage of five months pregnancy. He has used this frequently and successfully, and in case of emergency it will answer every purpose. Some months ago I saw a lady who had miscarried at five months. Five days after the fetus passed, a retained placenta was passed by the unaided efforts of nature; four days after this, I saw her in a dying condition with septicæmia. Was it proper to allow the placenta to remain such a length of time? Was this a wise course to pursue? Who can say: "This valuable life might not have been saved by the early removal of the retained placenta?" This case prompted me to present this paper for your thought and consideration.

#### TREATMENT OF POST-PARTUM ECLAMPSIA.

Dr. Strisover contributes a most interesting article on the treatment of post-partum eclampsia in a recent number of the *Journal de Méd. de Paris*. The treatment advocated by him, and used successfully in every case (ten) in which he has had occasion to try it, consists in hypodermic injections of the following solution:

**R** Chlorhydrate of Pilocarpine, gramme.....0. 05  
Water.....4. 00

Each injection to consist of a Pravaz syringe-ful of the solution.

The author closes his article with the following conclusions:

I. Chlorhydrate of pilocarpine is undoubtedly a trustworthy remedy in post-partum eclampsia.

II. Cardiac weakness is not a contra-indication for the repetition of the injections of pilocarpine if the eclamptic spasms reappear.

III. A return of the pupils to the normal size is an indication that the morbid process has not yet been conquered, and that the convulsions are about to recur.

#### PÆDIATRICS.

##### ETHERIZATION IN CROUP.

DR. F. BETZ contributes an article to the current issue of *Memorabilien*, which, though founded on only one case where etherization was tried as a treatment for croup, is yet of sufficient interest to merit notice. He commenced by pointing out that in croup the tendency towards death is by no means commensurate always with the morbid condition of the larynx anatomically considered, the nervous system often playing a considerable role. The case he describes was that of a child thirteen months old, to whom he was called by another practitioner in order to assist in the performance of tracheotomy. The child was breathing with the greatest difficulty, expiration and inspiration being equally noisy; the hypochondriac regions were strongly drawn in at each inspiration, also the lower intercostal spaces anteriorly; the alæ nasi were working strongly, and the child kept clutching at its throat, where the larynx was very prominent, and at its ears, and twisting its head round as if there were both pain and a sense of obstruction. It would not drink or stay in bed, the face wore an anxious expression, and the head was retracted. No membrane could be detected in the throat, and there was no sound of air entering the lungs when auscultated from behind. On the left side



percussion was dull from want of expansion of the lung. Altogether the case was apparently hopeless. Notwithstanding the dangerous character of tracheotomy in children so young, preparations were made for its performance, when the writer suggested that ether inhalations should first be tried. A mixture was ordered of three parts sulphuric ether, one part acetic ether, and one-tenth part menthol, of which three drops were given as an inhalation on a folded handkerchief every quarter of an hour. The idea was by means of the vapor of ether and menthol to act on the mucous membrane of the larynx, which, as is well known, lies somewhat higher than usual in croup, and thus to contract the bloodvessels, to lower the temperature of the part, to decrease the oedema, to lessen secretion, and to allay the irritation in the larynx by the production of some amount of local anaesthesia. In addition to these, Dr. Betz had the further object in view of inducing partial general anaesthesia so as to give the child rest, and to allay the spasmodic contractions of the muscles connected with respiration. In a couple of hours a decided change for the better had taken place, the child being quieter, and some air evidently entering the lungs. The inhalations were continued, therefore, but at intervals of half an hour. Six hours later the respiration had become much less noisy, the contractions less, and the dyspnoea far less urgent, enabling the child to drink. The face had regained its proper color, and the child was apparently pretty comfortable, so that there was no longer any need to think of tracheotomy. The regular administration of the inhalation was stopped, but another mixture of somewhat similar character, containing three-tenths of a part of menthol, was ordered, in case of any recurrence of the alarming symptoms. Fortunately the subsequent progress was so uniform that no recourse to this was required. The object of increasing the menthol was to obtain greater refrigeration and to enable it to penetrate further into the air passages. The writer remarks that Trousseau used to prescribe chloroform inhalations in croup, but he is disposed to prefer his own mixture of ether and menthol. Whether such etherization has any power to loosen false membranes further experiments must show; but when tracheotomy or intubation is for any reason inadmissible in undoubtedly membranous croup, this treatment may, he thinks, very fairly be tried. The inhalations ought not to be continuous, but intermittent, and the medical man should for the

first hour or two administer them himself.—*Brit. Med. Jour.*

## HYGIENE.

### PROGENY OF LEPERS.

In an analysis of 118 cases of leprosy in the Tantaran Asylum, in the Punjab, reported by Gulam Mustafa and read before the Epidemiological Society of London, by Dr. Phineas S. Abraham, we find the following relative to the progeny of lepers: Seventy-three of the total number appear to have been married before the onset of the disease, viz., forty-three males and thirty females; and whilst still in the healthy condition, the males are credited with seventy-one children, now or lately living, and in most cases free from the disease, and the females with sixty-five; total, 136. Only four females are stated to have given birth to offspring, five in all, after the disease had declared itself. Until recently, it was the custom to allow the patients to intermarry. Thirty-nine of those whose histories are recorded, viz., sixteen males and twenty-three females—availed themselves of the privilege, and seven of them married more than once; thus, one man united himself with no less than five leper wives, one after the other, and several other patients were married two or three times. Altogether, the number of marriages contracted by the men in the list amounts to twenty-six, and those of the females to twenty-nine. Only five of the men proved prolific, with a result of ten children and eight of the women with a result of fifteen children. Four of the children are dead, so that we have left twenty-one as the progeny of fifty-five marriages. As the notes give no information as to the names of the leper or lepers which each man or woman married, it is impossible to say whether the children and the marriages are not counted twice in the above collection. It is probable that the actual sterility is even greater than these figures indicate.—*St. Louis Med. and Surg. Jour.*

### TRANSMISSIBILITY OF SYPHILIS.

As published in his magnificent *Atlas of Venereal and Skin Diseases*, Prof. Morrow's conclusions in reference to the hereditary transmissions of syphilis are:

1. A syphilitic man may beget a syphilitic child, the mother remaining exempt from all visible signs of the disease;

the transmissive power of the father is, however, comparatively restricted.

2. A syphilitic woman may bring forth a syphilitic child, the father being perfectly healthy; the transmissive power of the mother is much more potent and pronounced, and of longer duration, than that of the father. When both parents are syphilitic, or the mother alone, and the disease recently acquired, the infection of the fetus is almost inevitable; the more recent the syphilis, the greater the probability of infection, and the graver the manifestation in the offspring.

3. While hereditary transmission is more certain when the parental syphilis is in full activity of manifestation, it may also be effected during a period of latency when no active symptoms are present.

\*4. Both parents may be healthy at the time of procreation, and the mother may contract syphilis during her pregnancy, and infect her child in utero. Contamination of the fetus during pregnancy is not probable if the maternal infection takes place after the seventh month of pregnancy.

#### MEDICAL CHEMISTRY.

##### SOLUBILITY OF IODOFORM IN OLIVE-OIL.

The solubility of iodoform in the fixed oils is stated somewhat variably. Squire gives 1 to 30 of olive-oil; Martindale "1 in 60 of vaseline and oil of almonds, and about the same in fats and other fixed oils." F. Klingmann (*Apoth. Zeit.*, 1831, 70) has recently determined the factor with care. Five grammes of iodoform were added to 30 grammes of olive-oil, the whole been shaken for twelve hours by means of a small turbine. Then it was filtered, and the saturated oil was found to contain between 2½ and 3 per cent. of iodoform. With due allowance for specific gravity, this shows the solubility of iodoform to be 1 part in 39 fluid parts of olive-oil.

##### UROLOGY IN CONNECTION WITH INFANTILE DISEASES.

*Albuminuria.*—The citro-picric acid reagent of Esbach is approved. First, filter the urine, then pour a few centimeters of it into a tube, and then an equal quantity of the reagent. If there is albumen the mixture will become opalescent, or there will be a precipitate. Frequently it may be necessary to reach the boiling point before the precipitation will take place. Examinations for albumen were made in two hundred and

fifty cases. In twenty-seven cases of pneumonia and broncho-pneumonia, albumen was found in large or small quantity. Albumen is usually associated with febrile oliguria; it disappears with defervescence and increases in the urine. It is a characteristic of all infectious diseases, though the rule is less absolute in children than in adults. In measles, albuminuria was present in 33 out of 34 cases, in scarlet fever in 34 out of 43, in erysipelas in 4 out of 5, in febrile roseola in 1, in typhoid fever in 5, in diphtheria in 36 out of 40; it was absent in 1 case of mumps and 2 of false croup. Albuminuria is transitory and not intense in most diseases with the exception of diphtheria, though in scarlatina it is present in a serious and rather permanent form in the secondary nephritis, which may occur as a complication. The albuminuria of diphtheria has no relation to the existence or intensity of the fever. It is present in fifty to seventy-four per cent of cases. In 10 cases of pulmonary tuberculosis albuminuria was present in 5, and in 4 out of 6 cases of tubercular meningitis. In 6 cases of whooping-cough it was found only once, in 1 case out of 3 of athrepsia in very young children, in 2 out of 3 cases of scrofulous cachexia with adenitis, in 1 case of acute perityphlitis, and in 1 of extensive burning. In 21 cases in which there was suppuration, especially in connection with carious bone, there was albumen in 11. Of 27 cases of nephritis, 21 occurred with infectious diseases, and 6 as chronic nephritis.

*Peptonuria.*—The peptones are hydrated albumens, soluble in water, diffusible, dialyzable, and not precipitated by heat, nitric acid, ferro-cyanide of potash, and acetic acid. They are easily precipitated by most of the reagents which precipitate the alkaloids, the precipitate being redissolved by heat and reappearing with cold. The reagents which are most frequently employed are phosphotungstic acid, phosphomolybdic acid, tannin, iodo-iodurated solutions, iodo-mercuric and citro-picric solutions. The search for this substance is made in the same way as for albumen. If a precipitate is obtained it may consist of albumen, peptones, alkaloids, or urate of sodium. If it should be albumen, it will not be dissolved when heat is applied. If it should consist of alkaloids or peptones, heat will dissolve it, but the alkaloids, and quinine in particular, will respond to particular reactions for such substances. The acid urate of sodium forms a finely granular precipitate

which appears more slowly than a precipitate of peptones; the latter will also give an opalescent appearance.

If there is any doubt remaining, it may be settled by the murexide test. If the urine is albuminous, the albumen may be eliminated by Hoffmeister's method. Eichwald and Gerhardt were the first to determine the presence of peptonuria, in cases of pneumonia, diphtheria, phosphorus poisoning, tertiary syphilis, petechial typhus, and dothi-enteritis. Jakach discovered it in certain conditions in which there was change in the blood, scorbutus being one of these conditions. In the general infectious diseases it is usually absent. Peptonuria has been divided into the following groups: nephrogenic, pyrogenic, puerperal, hæmatogenic, enterogenic, hepatic, and urogenic. The blood normally contains no peptones, hence its presence indicates a non-assimilable material which the kidney should eliminate. Peptones were sought by the author in 248 cases of disease in children, and were found in 34. It was found in 5 cases out of 28 of pneumonia and broncho-pneumonia, in 1 case out of 2 of purulent pleurisy, in 1 case of severe febrile roseola, in 10 cases out of 37 of diphtheria, in 3 cases out of 21 in which there was suppuration, in 1 case out of 6 of athrepsia, in 13 out of 23 of nephritis. In the 34 cases of peptonuria there were 32 in which there was also albuminuria. The methods of investigation now in use are not yet sufficiently exact.

**Diaceturia.**—If to normal urine a solution of perchloride of iron is added, there will be a precipitate of phosphate of iron; if perchloride of iron is still added, the precipitate will be dissolved and the urine will assume an amber color, or, in other cases, the color of red wine, which will become less marked by boiling, and will disappear if acids are added. These reactions will not take place if the urine is first submitted to prolonged boiling. Jakach considers this reaction due to aceto-acetic acid or its ethers, and he has given the name diaceturia to the elimination by the urine of its acetic acids, its salts, and its ethers. He has determined its presence in diabetes and in several febrile diseases, and has also found that it might exist as the expression of a particular auto-intoxication. Febrile diaceturia is of frequent occurrence but is not of serious prognostic significance.

In diabetes it is a grave symptom, and frequently announces the advent of coma. In 150 examinations the author determined diaceturia in 69. It was found 19 times in 23 cases of pneumonia and broncho-pneumonia, in 16 out of 26 of measles, in 27 out of

34 of scarlet fever, in 4 cases of erysipelas, in 11 out of 31 of diphtheria, in 2 out of 13 cases of suppuration, in 2 out of 4 of typhoid fever, in 2 out of 4 of tubercular meningitis, in 1 of acute perityphlitis, in 1 of extensive burning, in 2 out of 15 of acute nephritis, in 1 of solid tumor of the iliac fossa. Diaceturia may be considered as of frequent occurrence in infectious febrile diseases, and particularly in scarlet fever. It occurs exceptionally in uncomplicated diphtheria.—Binet's—*Rev. Mens. Mal. Enf.*

## NEWS AND MISCELLANY.

**RESULT OF KOCH'S TREATMENT.**—According to the *British Medical Journal*, 708 cases have been treated in external tuberculosis, 15 cured, 148 substantially improved, 237 improved, 298 unimproved and 9 died.

### MODERN DISCOVERIES OF NEW CURES.

With painful and patient pen we record the birth of a new treatment for phthisis, the sixth in four months. The hopeful author and discoverer this time is Dr. Tranjen, of Sistow, Bulgaria. He doesn't seem to have any front name, but that may be the fashion in Sistow. Professor Dr. C. A. Ewald writes a supplement to Dr. Tranjen's communication and also publishes the details in all their rosy tabulated promise in the *Berliner Klinische Wochenschrift*, an organ for practical doctors. The refrain which Dr. Tranjen plays upon Professor Ewald's organ is like that of other discoverers. We are having prepared a lithographed form for the benefit of future ingenious therapeutists in this same line. It will read like this:

"Form I.—Dr. — has discovered a new remedy for phthisis. He reports . . . cases. The results have so far been very satisfactory. In early stages it produces decided improvement and sometimes cure. In later stages it does not do so much good, but sometimes causes remarkable improvement before the patient ultimately dies. Dr. —'s new treatment promises to be a useful addition to our therapeutic armamentarium, and deserves further trial."

We shall be very glad to furnish "discovery blanks" of the above type to our clinical workers.

But meanwhile we had almost forgotten to say that Dr. Tranjen's new discovery consists in the hypodermic injection daily, for seven to ten days, of a solution of thymol-acetate of mercury, at the same time giving the patient iodide of potassium. The results are accurately described in Form I, as given above.—*Med. Rec.*